

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 52178**

PLACE OF DEATH

County of Lewiston
City of Lewiston

Registration District No. 0

Primary Registration District No. 100.9

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. _____

2. FULL NAME Baby Bales

(a) Residence. No. Grangeville St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Still Born

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 3, 1924

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Lewiston
(State or country)

10 NAME OF FATHER Larry Bales

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)

12 MAIDEN NAME OF MOTHER Myrl Rongstad

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 Informant H. Bales
(Address) Grangeville Idaho.

15 Filed Feb 9, 1926 Irwin E Bruce
Registrar

RECEIVED
FEB 15
BUREAU OF VITAL
STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 3, 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1926, to Jan 3, 1926, that I last saw him alive on Jan 3, 1926, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Premature birth (5 months)
Stillborn

CONTRIBUTORY (Secondary) Fall down stairs
one week before by mother
(duration) _____ yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) E. L. White M. D.
1-4, 1926 (Address) Lewiston ID

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial 1/4 1926

20. Undertaker Vassar Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Do not accept a certificate of death signed only by a midwife.

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RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

MAR 8

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 52498**

PLACE OF DEATH

County of Boone Registration District No. 30

City of Cornudas Primary Registration District No. 1057

Local Registrar's No. 1458

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Coventry

(a) Residence. No. 501 Indian St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Feb 22 - 1926

7 AGE Years Months Days
0 0 0 0
If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Cornudas
(State or country) Idaho

10 NAME OF FATHER

Neil S. Coventry

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Anna L. Lamm

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Idaho

14 Informant Neil S. Coventry

(Address) Cornudas, Idaho

15 Filed March 5 - 1926 D. D. Drennan
Registrar

16 DATE OF DEATH

Feb. 23 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on Feb 22, 19____, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Still Born.
6 months baby.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.
Albuminuria of Mother
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) D. D. Drennan, M. D.
Feb 22, 1926. (Address) Cornudas

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19 Place of Burial, Cremation, or Removal

Date of Burial

Forest Cemetery 2/22 1926
20. Undertaker Address

R. B. Drennan

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

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Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

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RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 52601**

PLACE OF DEATH

APR 5

CERTIFICATE OF DEATH

County of **Ada**

BUREAU OF VITAL STATISTICS

Registration District No. **2**

City of **Boise**

Primary Registration District No. **1004**

Local Registrar's No. **81**

(No. **St. Alphonsus Hospital**)

(If death occurred in hospital or institution give its name instead of street and number.)

2. FULL NAME **Engine Steward Thomas**

(a) Residence. No. **2411 W. Holladay** St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

Mar. 21-1926

7. AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Boise Idaho

10. NAME OF FATHER

George B Thomas

11. BIRTHPLACE OF FATHER (city or town) (State or country)

12. MAIDEN NAME OF MOTHER

Jessie A. Steward

13. BIRTHPLACE OF MOTHER (city or town) (State or country)

Kansas

14. Informant

(Address)

George B. Thomas
2411 W. Holladay Ave. Boise

15. Filed

Mar 22 1926

D. H. Pratt

Registrar

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH

3
(Month)

21
(Day)

26
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,

that I last saw h. _____ alive on _____, 19_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Born
Isolaps umbilical Cord
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

Asphyxia pressure on Cord. (duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ____ Date of ____

Was there an autopsy? **yes**

What test confirmed diagnosis?

(Signed) **Fred O. Tuttle**, M. D.

3/22, 19**26** (Address) **Boise**

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Morris Hill Cemetery **May 22 1926**

20. Undertaker

Address

Summers & Krebs **Boise, Id.**

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RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 53709**

PLACE OF DEATH

JUL 1

CERTIFICATE OF DEATH

County of Ada Bureau of Vital Statistics District No. 2

City of Boise Primary Registration District No. 1004

Local Registrar's No. 167

(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Irvin Parritt

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OF RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than day, min. hrs. Still Born

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boise Ida
(State or country)

PARENTS

10 NAME OF FATHER Ralph Parritt

11 BIRTHPLACE OF FATHER (city or town) Ida.
(State or country)

12 MAIDEN NAME OF MOTHER Marvel Dutton

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant Leann A. Dobson
(Address) Boise Ida

15 Filed 6-29 19 26 R. W. Parritt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 29 19 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw him alive on _____, 19____,
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Still Born

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Chas. Parker, M. D.

_____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Morris Hill Cemetery 6/29 19 26

20. Undertaker Schuber & Davis Address Boise

Parker.

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Payette*City of *Payette*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *4*RECEIVED
MAR 31
BUREAU OF VITAL STATISTICS

St.)

State File No. *S 52988*Local Registrar's No. *18*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

Mar 15 1926
(Month) (Day) (Year)

7. AGE

*Stillborn*IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Fred G. Wheeler

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Josephine Sanderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Mar 16 1926**J. C. Woodward*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 15 1926
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Mar 15 1926* to *Mar 15 1926*that I last saw him alive on *19*,and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *N. D. Wiese*1926 (Address) *Butte Ore*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

Usual residence

19. PLACE OF BURIAL OR REMOVAL

Payette Idaho

DATE OF BURIAL

Mar 16 1926

20. UNDERTAKER

Johnson & Co

ADDRESS

Payette Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

MAY 1

BUREAU OF VITAL STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

DO NOT WRITE IN THIS SPACE

S 53389

State File No.

PLACE OF DEATH

County of Bannock Registration District No. 28

City of Paestum Primary Registration District No. 217

(No. 826 N. 7 Ave)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Campanella

(a) Residence. No. 826 N. 7 Ave St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Italian 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE 2 Years 0 Months 0 Days If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Paestum, Italy (State or country)

10 NAME OF FATHER Jim Campanella

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Lucia Penella

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

PARENTS

14 Informant Jim Campanella (Address) 826 N. 7 Ave

15 Filed 4-18, 1926

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4-17 17 1926 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 4-17, 1926 to 4-17, 1926 that I last saw him alive Dead 4-17-26 1926 and that death occurred, on the date stated above, at 109 m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism - Pneumonia

(duration) ____ yrs. ____ mos. ____ ds. CONTRIBUTORY Refused Hospital Care (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis?

(Signed) J. Young M. D. 4-18, 1926 (Address) Paestum

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Mountain View Date of Burial 4-18 1926

20 Undertaker Schumacher & Sons Address City

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

Place holder to be
replaced with certificate

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. <u>26</u>		File No. <u>S 53632</u>	
County of <u>Quincy</u>		Primary Registration District No. <u>2069</u>		Registered No. <u>1896</u>	
City of <u>Malad</u> (No. <u>4</u> , St.)		If death occurs away from usual residence, give facts called for under special information.		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
RECEIVED JUN 4 1926 BUREAU OF VITAL STATISTICS					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH.		
3. SEX <u>Male</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Child</u>	
6. DATE OF BIRTH <u>May 30 1926</u>		(Month) (Day) (Year)		16. DATE OF DEATH <u>May 30 1926</u>	
7. AGE <u>18 yrs.</u>		IF LESS than 1 day how many hrs. or mins.?		17. I HEREBY CERTIFY, That I attended deceased from <u>May 30 1926</u> to <u>May 30 1926</u> that I last saw him alive on <u>May 30 1926</u> and that death occurred on the date stated above, at <u>11:30</u> A.M.	
8. OCCUPATION		The CAUSE OF DEATH* was as follows:			
(a) Trade, profession or particular kind of work		<u>Infant</u>			
(b) General nature of industry business, or establishment in which employed (or employer)		<u>Still Born</u>			
9. BIRTHPLACE <u>Malad Ida.</u>		(Duration) yrs. <u>1 1/2</u> mos. ds.			
10. NAME OF FATHER <u>Lo M. Camp</u>		Contributory (Secondary) <u>none</u>			
11. BIRTHPLACE OF FATHER <u>Utah</u>		(Duration) yrs. mos. ds.			
12. MAIDEN NAME OF MOTHER <u>Eunice E. Dillie</u>		(Signed) <u>D. M. Mabey</u> M. D.			
13. BIRTHPLACE OF MOTHER <u>Utah</u>		1926 (Address) <u>Malad</u>			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>L. M. Camp</u>		*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.			
(Address) <u>Malad Ida.</u>		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)			
15. Filed <u>6/5/26</u> 1926 <u>J. M. Kerns</u> Local Registrar		At place of death. yrs. mos. days. In the State. yrs. mos. days.			
		Where was disease contracted, if not at place of death? <u>RECEIVED JUN 4 1926</u>			
		Former or usual residence.			
		19. PLACE OF BURIAL OR REMOVAL <u>St. John's Cemetery Malad Ida.</u>		DATE OF BURIAL <u>June 2 1926</u>	
		20. UNDERTAKER <u>J. Guy Benson</u>		ADDRESS <u>Malad Ida.</u>	

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

1. PLACE OF BIRTH
County of Ada
City of _____
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 53709

Registration District No. _____ State File No. _____

Prim. Registration District No. _____ Local Registrar's No. _____

(If born in hospital or institution give name.)

2. FULL NAME OF CHILD Porritt

3. Sex	If plural births { 4. Twin, triplet, or other _____ 5. Number, in order of birth _____	6. Premature _____ Full term _____	7. Legiti- mate? _____	8. Date of birth <u>06/27</u> , 19 <u>26</u> (Month, Day, Year)
--------	---	---------------------------------------	---------------------------	--

9. Full name <u>Porritt</u> FATHER	18. Full maiden name <u>Dotson</u> MOTHER
---------------------------------------	--

10. Residence (usual place of abode) (If non-resident, give place and State) _____	19. Residence (usual place of abode) (If non-resident, give place and State) _____
---	---

11. Color or race _____	12. Age at last birthday _____ (years)	20. Color or race _____	21. Age at last birthday _____ (years)
-------------------------	--	-------------------------	--

13. Birthplace (city or place) (State or Country) _____	22. Birthplace (city or place) (State or Country) _____
--	--

OCCUPATION	14. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____	OCCUPATION	23. Trade, profession, or particular kind of work done, as housekeeper, typist, nurse, clerk, etc. _____
	15. Industry or business in which work was done, as silk mill, sawmill, bank, etc. _____		24. Industry or business in which work was done, as own home, lawyer's office, silk mill, etc. _____
	16. Date (month and year) last engaged in this work _____, 19 _____		17. Total time (years) spent in this work _____

27. What prophylactic was used to prevent Ophthalmia Neonatorum? _____

28. Number of children of this mother (At time of this birth and including this child)
(a) Born alive and now living _____ (b) Born alive but now dead _____ (c) Stillborn _____

29. If stillborn, period of gestation _____ { months or weeks	30. Cause of stillbirth _____ { Before labor _____ During labor _____
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____ m. on the date above stated.
(Born Alive or Stillborn)

(Signed) _____, M. D.

or _____, Midwife

Address _____

Filled _____, 193 _____

When there was no attending physician or midwife, then the father, householder, etc., should make this return.

Give name added from a supplemental report _____

(Date of)

Registrar.

Registrar.

RECEIVED JUL 10 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 53749**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of BannockRegistration District No. 28City of PostvillePrimary Registration District No. 2161Local Registrar's No. 4822(No. St. Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Infant Bowman(a) Residence. No. Sheepskin Idaho

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OF RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE 26 Months Days If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Idaho
(State or country)10 NAME OF FATHER W. J. Bowman11 BIRTHPLACE OF FATHER (city or town) Iowa
(State or country)12 MAIDEN NAME OF MOTHER Amanda Taggart13 BIRTHPLACE OF MOTHER (city or town) Utah
(State or country)14 Informant W. J. Bowman
(Address) Sheepskin Idaho15 Filed 6/3, 1926Registrar W. J. Bowman

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 4 1926

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from June 4, 1926, to June 6, 1926, that I last saw him alive on Stillborn and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Still born
Difficult labor, Transverse
position fetus, Version
(duration) ____ yrs. ____ mos. ____ ds.CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? no Date of ____Was there an autopsy? noWhat test confirmed diagnosis? Obstetrical auscultation(Signed) Dr. F. Howard, M. D.6/4, 1926 (Address) Postville Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Mountain View Date of Burial June 4 192620 Undertaker Schumacher Address Postville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAINTAIN RESERVE FOR DURING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—In case of more than one child at birth a Separate Return must be made for each, and the number of each, in order of birth stated.

1. PLACE OF BIRTH
County of Butte
City of _____
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 53845

Registration District No. _____ State File No. _____

Prim. Registration District No. _____ Local Registrar's No. _____

(If born in hospital or institution give name.)

2. FULL NAME OF CHILD Bladh

3. Sex	If plural births { 4. Twin, triplet, or other _____ 5. Number, in order of birth _____	6. Premature _____ Full term _____	7. Legiti- mate? _____	8. Date of birth <u>05/27</u> , 19 <u>26</u> (Month, Day, Year)
--------	---	---------------------------------------	---------------------------	--

9. Full name <u>Bladh</u>	FATHER	18. Full maiden name <u>Steele</u>	MOTHER
---------------------------	--------	------------------------------------	--------

10. Residence (usual place of abode) (If non-resident, give place and State) _____	19. Residence (usual place of abode) (If non-resident, give place and State) _____
---	---

11. Color or race _____	12. Age at last birthday _____ (years)	20. Color or race _____	21. Age at last birthday _____ (years)
-------------------------	--	-------------------------	--

13. Birthplace (city or place) (State or Country) _____	22. Birthplace (city or place) (State or Country) _____
--	--

OCCUPATION	14. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____	OCCUPATION	23. Trade, profession, or particular kind of work done, as housekeeper, typist, nurse, clerk, etc. _____
	15. Industry or business in which work was done, as silk mill, sawmill, bank, etc. _____		24. Industry or business in which work was done, as own home, lawyer's office, silk mill, etc. _____
	16. Date (month and year) last engaged in this work _____, 19 _____		17. Total time (years) spent in this work _____

27. What prophylactic was used to prevent Ophthalmia Neonatorum? _____

28. Number of children of this mother (At time of this birth and including this child)
(a) Born alive and now living _____ (b) Born alive but now dead _____ (c) Stillborn _____

29. If stillborn, period of gestation _____ { months or weeks	30. Cause of stillbirth _____ { Before labor _____ During labor _____
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____ m. on the date above stated.
(Born Alive or Stillborn)

(Signed) _____, M. D.

or _____, Midwife

Address _____

Filed _____, 193 _____

Registrar.

Registrar.

When there was no attending physician or midwife, then the father, householder, etc., should make this return.

Give name added from a supplemental report _____

(Date of) _____

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

RECEIVED CERTIFICATE OF DEATH
Registration District No. 98
BUREAU OF VITAL STATISTICS
Vital Statistics District No. 2176
St.)

Infant

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

1-27-26

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **53946**

1. PLACE OF DEATH

County of *Jefferson*City of *Regley*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *98*Primary Registration District No. *2176*

BUREAU OF VITAL STATISTICS

St.)

Registered No. *15*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Apr. 30

(Month)

(Day)

1926
(Year)

7. AGE

Stillborn

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Babe (Stillborn)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Lawrence Byler

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Kellie Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lawrence Byler

(Address)

Regley, Ida.

15.

Filed

*May 10 1926**Rayn Pike*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 30

(Month)

(Day)

1926
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Born dead 2 wks. apparently when born. Was full term. Possible end of pregnancy.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. H. A. Anderson

19.....

(Address)

Regley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Little Butte Cemetery**Apr. 30 1926*

20. UNDERTAKER

ADDRESS

*Friends**Regley, Ida.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

RECEIVED JUL 12 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 54075**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Twain Falls Registration District No. 37City of " Primary Registration District No. 2085(No. Dr. J. E. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. _____

2. FULL NAME

(a) Residence. No. 4th Ave. East St. Burson

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) June 16 1926

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Twain Falls
(State or country)10 NAME OF FATHER M. A. Burson11 BIRTHPLACE OF FATHER (city or town) Ido.
(State or country)12 MAIDEN NAME OF MOTHER Bonnie Herriman13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)14 Informant M. A. Burson
(Address) Twain Falls15 Filed July 26 1926 John Floughlin
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 10 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still bornCONTRIBUTORY (Secondary) Probably an intracranial hemorrhage during passage thru birth canal
(duration) yrs. mos. ds.18 Where was disease contracted
If not at place of death? ☒Did an operation precede death? ☒ Date of _____Was there an autopsy? noWhat test confirmed diagnosis? none
(Signed) John Floughlin, M. D.
6-15, 1926 (Address) Twain Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Twain Falls Date of Burial June 14 192620 Undertaker J. J. Gosman Twain FallsWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAINTAIN RESERVED FOR BUREAU

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

54480

Local Registrar's No. 723

(If nonresident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

Single

(Year)

Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms, so that it may be properly classified. Exact statement of **OCUPATION** is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

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DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

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Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 10-1-10

SEP 12 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Berninah
City of St. MariesRegistration District No. 32
Primary Registration District No. 2049
(No. _____ St.)State File No. S 54714
Local Registrar's No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucille L'equie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED X
(Write the word)

6. DATE OF BIRTH

July 1926
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) St. Maries Ida

10. NAME OF FATHER

Lud Vigue

11. BIRTHPLACE OF FATHER

(State or Country) Mich

12. MAIDEN NAME OF MOTHER

Mary Kallan

13. BIRTHPLACE OF MOTHER

(State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lud Vigue
(Address) St. Maries Ida

15.

Filed July 5 1926 Cheney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 1926
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1926 to Aug 5 1926that I last saw him alive on _____ 1926
and that death occurred on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH was as follows:

Shel born(Duration) yrs. mos. ds.
Contributory (Secondary) Intro of term Pharynx
g m h 2 hr(Duration) yrs. mos. ds.
(Signed) Robert D. Platt M. D.
Aug 5 1926 (Address) St. Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Woodman

DATE OF BURIAL

Aug 5 1926

20. UNDERTAKER

Hubert McVey

ADDRESS

St. Maries Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **20 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 15 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 55013**

PLACE OF DEATH
County Lewin Falls
City of Trinity

Registration District No. 36

Primary Registration District No. _____

Local Registrar's No. _____

(If death occurred at hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Owens(a) Residence. No. 1000 Kimberly St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Aug 13 - 1926

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min.
0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Trinity Idaho
(State or country)10 NAME OF FATHER HC Owens11 BIRTHPLACE OF FATHER (city or town) Lynn
(State or country)12 MAIDEN NAME OF MOTHER Rochael Brown13 BIRTHPLACE OF MOTHER (city or town) Lynn
(State or country)

14 Informant HC Owens
(Address)

15 Filed Aug 24 26 J. M. Davis
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) Aug (Day) 13 (Year) 1926

17 I HEREBY CERTIFY, That I attended deceased from

Still born, 19____, to Aug 13, 1926.

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Still born -

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY Probably toxic
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Dr. J. M. MorganAug 13, 1926, (Address) Lynn Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Lynn Falls Idaho 8/18 1926

20. Undertaker

Address

J. E. De Witt Lynn Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (a) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

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term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED NOV 8 1926
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **55054**

PLACE OF DEATH

County of Ada Registration District No. 7City of Bosse Primary Registration District No. 1004Local Registrar's No. 262(No. St. Alphonsus Hospital)
2. FULL NAME Baby Martin (If nonresident give city or town and State.)
Virginia Martin(a) Residence. No. 1503 - Main St. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of HARRY MARTIN

6 DATE OF BIRTH (month, day and year)

8/10/26

7 AGE

Years

Months

Days

If LESS than
1 day, min. hrs.
or day, min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Mother of infant
Help in American

(b) General nature of industry, business, or establishment in which employed (or employer)

Secretary

(c) Name of employer

Mr. Birmingham

9 BIRTHPLACE (city or town), (State or country)

Charleston W. Virginia
Bosse Virginia

10 NAME OF FATHER

Harry Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Spokane

12 MAIDEN NAME OF MOTHER

Virginia Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Charleston W. Virginia

14 Informant

(Address)

Virginia Martin
1503 - Main St.

15

Filed

10-8, 1926R. N. Pratt

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct
(Month)7
(Day)1926
(Year)17 I HEREBY CERTIFY, That I attended deceased from
10/7, 1926, to 10/7, 1926.
that I last saw him alive on 10/7, 1926
and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Stillborn
premature 5 1/2 months

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ____Was there an autopsy? noWhat test confirmed diagnosis? Phys Exam.(Signed) F. E. Burdett, M. D.10/7, 1926 (Address) Bosse Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Ada County Cemetery 10/8 1926

20. Undertaker

Address

Schreiber & Davis Bosse

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. N. **RECEIVED** NOV 12 1926 **CERTIFICATE OF DEATH**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Ada*
City of *Furness Falls*

Registration District No. *37*
Primary Registration District No. *1085*
(No. *Co. Gen. Hosp.* St.)

State File No. **S 55347**
Local Registrar's No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(unnamed) Chapman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female *white* *single*
(Write the word)

6. DATE OF BIRTH

Oct - 29 1926
(Month) (Day) (Year)

7. AGE

0 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?
0 hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Walter P. Chapman

11. BIRTHPLACE OF FATHER

(State or Country) *Nebr.*

12. MAIDEN NAME OF MOTHER

Ethel May Nelson

13. BIRTHPLACE OF MOTHER

(State or Country) *Colo.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. P. Chapman
(Address) *Kimberly Idaho*

15.

Filed *11-1-*

1926

John F. Longline
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 29 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 29 1926 to Oct 29 1926

that I last saw him *at Stillman* 19...
and that death occurred on the date stated above, at *11 A.M.*

The CAUSE OF DEATH* was as follows:

Premature birth
Induced labor
Toxemia of pregnancy
8th month of gestation
(Duration) *9* yrs. mos. ds.
Contributory (Secondary) *?*
(Duration) *9* yrs. mos. ds.

(Signed) *J. R. Davis* M. D.
1930 1926 (Address) *Kimberly, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Filer, Ida.

DATE OF BURIAL

10-29 1926

20. UNDERTAKER

Father
Walter Chapman Kimberly

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 12 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

55353

PLACE OF DEATH
County of Twin Falls
City of _____

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. _____

(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Baby Craig

(a) Residence. No. 402 - 6th Beach St.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct. 23-1926

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min.
0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Idaho - Twin Falls

10 NAME OF FATHER

Orvie Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Missouri

12 MAIDEN NAME OF MOTHER

Mable Morrisett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Missouri

PARENTS

14 Informant

Orvie Craig

(Address)

Twin Falls Idaho

15

Filed

Nov. 10, 1926 John F. Goughlin
Registrar

MEDICAL CERTIFICATE OF DEATH

1896

16 DATE OF DEATH

Oct 23 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased ~~from~~

10-23, 1926, to 19

that I last saw h. _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Mal. nutrition
Stillborn

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

Don't know

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) PAKMAN M. D.
10-23, 1926 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Twin Falls

Oct 25 1926

20. Undertaker

Address

J. E. We Witt

Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 55421**

Local Registrar's No. **4451**

PLACE OF DEATH
County of **Bannock**
City of **Pocatello**

Registration District No. **28**
Primary Registration District No. **2161**

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Infant Shilts**

(a) Residence. No. **R.F.W. #1, Pocatello, Ida.** St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **female** 4 COLOR OR RACE **white** 5 Single, Married, Widowed, or Divorced (write the word) **single**

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) **Nov. 17, 1926**

7 AGE Years Months Days **Stillborn** If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **none**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) **Pocatello**
(State or country) **Idaho**

10 NAME OF FATHER **Lawrence Shilts**

11 BIRTHPLACE OF FATHER (city or town) **Washington**
(State or country)

12 MAIDEN NAME OF MOTHER **Bessie Hudson**

13 BIRTHPLACE OF MOTHER (city or town) **Oklahoma**
(State or country)

14 Informant **Lawrence Shilts**
(Address) **R.F.W. #1, Pocatello Idaho**

15 Filed **11/19, 1926** **H. L. Mc Han** Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **November 17, 1926**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **Nov 17, 1926**, to **Nov 17, 1926**, that I last saw **her** ~~alive~~ on **Nov. 17, 1926**, and that death occurred, on the date stated above, at **5:30 p.m.**

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) **Frequent eclampsia of mother.**
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death? **No**
Did an operation precede death? **No** Date of ____
Was there an autopsy? **No**
What test confirmed diagnosis?
(Signed) **W. W. Brothman, M. D.**
11-19, 1926 (Address) **Pocatello Idaho**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal **Mountain View Cemetery** Date of Burial **Nov. 19, 1926**
20. Undertaker **H. L. Mc Han** Address **Pocatello, Idaho**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25-11-12
RECEIVED NOV 23 1926
CERTIFICATE OF DEATH
1. PLACE OF DEATH
County of Ben Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Baby Freeman

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. S 55445
Local Registrar's No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Infant
(Write the word)

6. DATE OF BIRTH Sept. 6 1926
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day how many _____ hrs. or _____ min.?
_____ Yrs. _____ Mos. _____ ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father Owen Freeman

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Grace Barkhill

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Owen Freeman
(Address) Georgetown, Idaho

15. Filed 11/20/26 HN King
19 26 Local Registrar

MEDICAL CERTIFICATE OF DEATH 1896

16. DATE OF DEATH - Sept 6 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1926 to Sept 6 1926, that I last saw him alive on Sept 6 1926 and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Stillbirth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Russell T. Egert M. D.
Sept 7 1926 (Address) Boonville, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Georgetown, Idaho DATE OF BURIAL Sept 7 1926
20. UNDERTAKER J. M. Williams ADDRESS Montpelier, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

RECEIVED DEC 2 - 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 55542**

PLACE OF DEATH

County of Bennville
City of Idaho Falls

CERTIFICATE OF DEATH

Registration District No. 73Primary Registration District No. 2140(No. Spencer Hospital)Local Registrar's No. 169

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Graham(a) Residence. No. Idaho Falls, Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) November 1, 1926

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.000

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work. Baby(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Idaho Falls, Idaho
(State or country)

10 NAME OF FATHER

William Graham11 BIRTHPLACE OF FATHER (city or town)
(State or country)Idaho

12 MAIDEN NAME OF MOTHER

Butler13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Missouri

14 Informant

(Address)

W. W. Graham

15 Filed

Nov 319 26W. W. Graham

Registrar

16 DATE OF DEATH

November
(Month)1
(Day)1926
(Year)17 I HEREBY CERTIFY, That I attended deceased from
Nov. 1, 1926, to Nov. 1, 1926,that I last saw him or alive on stillborn, 1926,and that death occurred, on the date stated above, at 8-30a m.

The CAUSE OF DEATH* was as follows:

Stillborn - Dead for several
days -

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? yes Date of _____Was there an autopsy? yesWhat test confirmed diagnosis? micro

(Signed)

W. W. Graham11/319 26

(Address)

Idaho Falls, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Rose Hill, Idaho FallsNov. 3 19 26

20. Undertaker

Address

J.A. WoodIdaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 10 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 55690**

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. Providence Hospital)

Local Registrar's No. 120

(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Mastes Newcomb

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

16 DATE OF DEATH

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

none

17 I HEREBY CERTIFY that I attended deceased from

Premature Birth 19 Nov 9 to Nov 9, 19 26

that I last saw him alive on Nov 9, 19 26

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH was as follows:

Premature Birth
still born

6 DATE OF BIRTH (month, day and year) Nov 9 1926

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wallace
(State or country) Idaho

10 NAME OF FATHER Vern Newcomb

11 BIRTHPLACE OF FATHER (city or town) Spokane Wash
(State or country)

12 MAIDEN NAME OF MOTHER Edith Burdette

13 BIRTHPLACE OF MOTHER (city or town) Canada
(State or country)

14 Informant Vern Newcomb
(Address) Mullan 2dg

15 Filed Nov 10, 19 26 H. L. Quigley
Registrar

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) H. W. Rolfs M. D.
Nov 10, 19 26 (Address) Mullan 2dg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Wallace 2dg Date of Burial Nov 10, 19 26

20. Undertaker Hard Wood Co Address Wallace 2dg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **55786**

1. PLACE OF DEATH **RECEIVED JAN 8 1927 121**
County of **Bonneville** Primary Registration District No. **2194**
City of **Shelley** (No. _____ St. _____)

Registered No. **121**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Baby Murphy**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH.

12 - 28 - 1926
(Month) (Day) (Year)

7. AGE

Still born
Yrs. _____ Mos. _____ ds. _____
IF LESS than 1 day
hrs. _____ min. _____

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

None

9. BIRTHPLACE

(State or Country)

Shelley -

10. NAME OF FATHER

Alfred Earl Murphy

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

June Oaker

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

E. E. Murphy
Shelley

15.

Filed **Dec 30 1926** **W. O. Oaker** Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 - 28 - 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth
that I last saw him alive on **1926**

and that death occurred on the date stated above, at **9 P. M.**

The CAUSE OF DEATH* was as follows:

Still birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **Shelley** M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days In the State... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelley Idaho Cem. **Dec 30 1926**

none ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 15 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 56279

S

PLACE OF DEATH

County of Jerome
City of Eden

CERTIFICATE OF DEATH

Registration District No. 23

Primary Registration District No. 2017

Local Registrar's No. 7

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eugene Conely

(a) Residence. No. Eden Ida St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. d. How long in U. S., if of foreign birth? yrs. mos. d. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE wh 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct 5 1926

7 AGE Years Months Days If LESS than 1 day or no min. hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Eden Ida
(State or country)

10 NAME OF FATHER Louis Conely

11 BIRTHPLACE OF FATHER (city or town) no
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Anderson

13 BIRTHPLACE OF MOTHER (city or town) no
(State or country)

14 Informant Bessie Conely
(Address) Eden Ida.

15 Filed _____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 5 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1926, to Oct 5, 1926, that I last saw him alive on Oct 5, 19____, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:
Dist. from strangulation. (unusually long cord wound around neck, arm and body.)
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY _____
(Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no. Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Glucose
(Signed) E. H. Berry, M. D.
Oct 5, 1926 (Address) Harlem Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Harlem Ida Date of Burial Oct 6 1926

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLA RECEIVED APR 13 1927

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 56904

County of FREMONT

Registration District No. 102

City of ASHTON

Primary Registration District No. 6

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME STILLBORN, BOWMAN.

(a) Residence. No. St.

(Usual place of abode) Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX MALE 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 9th 1926

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work AT HOME

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ASHTON IDAHO (State or country)

10 NAME OF FATHER I. E. BOWMAN.

11 BIRTHPLACE OF FATHER (city or town) PENN. (State or country)

12 MAIDEN NAME OF MOTHER CLARA NEIFERT

13 BIRTHPLACE OF MOTHER (city or town) IOWA (State or country)

14 Informant I. E. BOWMAN (Address) ASHTON

15 Filled 12/10/26 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

DEC. 9th/1926 19 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 19 to 19, that I last saw h. alive on 10 P.M. and that death occurred, on the date stated above, at 10 P.M.

THE CAUSE OF DEATH* was as follows:

Still Born. Do not know cause of death. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed Dec 9 1926 (Address) Ashton Idaho M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal ASHTON IDAHO Date of Burial 12/10/26 19

20. Undertaker LEWIS KISER ASHTON IDAHO Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **60985** **S**

PLACE OF DEATH

County of Jerome
City of Jerome

Registration District No.
Primary Registration District No.

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Fritzler
(a) Residence. No. St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <u>Mar. 27, 26</u>		
7. AGE	Years	Months
	Days	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER <u>Harry Fritzler</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Melrocks</u>
12. MAIDEN NAME OF MOTHER <u>Hazel Jenkins</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Colorado</u>

14. Informant Harry Fritzler
(Address) Jerome

15. Filed _____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 27, 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw h. _____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Still Born infant
Don't know.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Chas. F. Zeller, M. D.
Mar. 29, 1926 (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Jerome Cemetery Date of Burial Mar 28 1926

20. Undertaker J. A. Harrison Address Jerome

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

N. B.—Every item of information should be carefully supplied. AGE should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms, so that it may be properly classified. **Exact statement of OCCUPATION** is very important. See instruction on back of certificate.

State File No. **S 60999**

Local Registrar's No.....

If death occurred in a hospital or institution, give its name instead of street and number.)

Length of residence in city or town where death occurred.	yrs.	mos.	ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.
---	------	------	-----	---	------	------	-----

15. Filed _____, 19____

20	Undertaker		Address	
----	------------	--	---------	--

Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

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spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Kootenai

FEB 5

BUREAU OF VITAL CERTIFICATE OF BIRTH

138279

City of Rose Lake

No. 15411708165

St. Registration District No. 126

State File No. 9

Hospital

Primary Registration District No. 2364

Local Registrar's No. 36

FULL NAME OF CHILD

Baby Anderson

(Certificate of no value without full name of child)

Sex of
Child

M

Twin
Triplet
or other?

and { Number
in order
of birth

1st

Legiti-
mate?

Yes

Date of
birth

Jan 17

1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Still born

Number of child of this mother, including present birth

6th

Number of child of this mother now living, including present birth

5

FULL
NAME

FATHER

Fred W Anderson

RESIDENCE

2 M. E. Rose Lake

COLOR

W

AGE AT LAST
BIRTHDAY

31

(Years)

BIRTHPLACE

Newburg Mich

OCCUPATION

Lumberjack

FULL
MAIDEN
NAME

MOTHER

Leora Mary Jones

RESIDENCE

Same

COLOR

W

AGE AT LAST
BIRTHDAY

37

(Years)

BIRTHPLACE

Grand Marais Mich

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at Rose Lake Idaho M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. F. Schrader

(Physician or midwife)

Address

Rose Lake

Filed

Feb 1 1926

Registrar.

Registrar.

[Handwritten signature]

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6-204
6-205

30420123.7

30A-341-118

DATE OF ATTENDING PHYSICIAN

There is one other matter which I should like to mention. I have been thinking about the fact that the Government has been very generous in its treatment of the people of the South. I have been thinking about the fact that the Government has been very generous in its treatment of the people of the South. I have been thinking about the fact that the Government has been very generous in its treatment of the people of the South.

...and the world is a very different place...

• **Texting:**

18-16343

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 521179

Local Registrar's No. 7

PLACE OF DEATH

RECEIVED

CERTIFICATE OF DEATH

County of Kootenai FEB 5 Registration District No. 126

City of Rose Lake, Idaho Primary Registration District No. 2307

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Baby Anderson

(a) Residence. No. 2 Miles East St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

S

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

—

6 DATE OF BIRTH (month, day and year)

Jan. 17, 1926

7 AGE

Years Months Days

Still born

If LESS than
1 day, ____ hrs.
or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Rose Lake, Idaho

10 NAME OF FATHER

Fred W Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Newberg, Idaho

12 MAIDEN NAME OF MOTHER

Gair & Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Grand Rapids, Idaho

14

Informant

F. W. Anderson

(Address)

Rose Lake, Idaho

15

Filed

Feb 1 1926 Karl J May Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 17 1926

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 17, 1926, to Jan 17, 1926

that I last saw him alive on Jan 17, 1926

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Still born - partly decomposed when born

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. F. Schrecker

Jan 17, 1926 (Address) Rose Lake, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Rose Lake, Idaho

Date of Burial

Jan 18 1926

20. Undertaker

none

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

413 109 028 844
PLACE OF BIRTH

RECEIVED
FEB 10
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai
City of Conrad Allen
No. 1 St. Registration District No. 30 State File No. 138304
Hospital 1 Primary Registration District No. 1051 Local Registrar's No. 1485
FULL NAME OF CHILD James Allen MacDonald
(Certificate of no value without full name of child)
Sex of Child Male { Twin or other? one } and { Number in order of birth one } Legitimate? yes Date of birth Jan 9 1926
(Month) (Day) (Year)

What bactericidal solution was used in eyes? 1
Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2
FULL NAME FATHER James MacDonald FULL MAIDEN NAME MOTHER Margaret Agnes Hume
RESIDENCE Conrad Allen RESIDENCE Conrad Allen
COLOR white AGE AT LAST BIRTHDAY 36 (Years) COLOR white AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Michigan BIRTHPLACE Michigan
OCCUPATION Rancher OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE

I hereby certify that I attended the birth of this child, who was { born alive } at 830 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192_____
Registrar.

(Signature) W. H. Holden
Physician
(Physician or midwife)
Address Conrad Allen
Filed Feb 6 1926 O. Drennon
Registrar.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE ACT OF MARCH 3, 1903, ONLY IN CASES WHERE THE BIRTH OF THE CHILD IS NOT REGISTERED IN THE STATE OF IOWA.

PLACE OF BIRTH

STATE OF IOWA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

188304

CERTIFICATE OF BIRTH

No. _____ City of _____ County of _____

Hospital _____

NAME OF CHILD _____

Sex of _____

What obstetrical solution was used in case? _____

Number of child of this mother, including a still birth _____

Number of child of this father, including a still birth _____

FATHER FULL NAME _____

RESIDENCE _____

COLOR _____

AGE AT LAST BIRTHDAY _____

BIRTHPLACE _____

OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____

on the date above stated.

When there was no attending physician _____

or midwife, then the father, grandfather _____

or other person should make this return. A witness _____

shall be one that neither prescribes nor _____

gives names added from a supplemental report _____

Signature _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 52095

Local Registrar's No. 1433

PLACE OF DEATH

FEB 10

CERTIFICATE OF DEATH

30

County of Kootenai

Registration District No.

City of Coeur d'Alene

Primary Registration District No. 1031

(No. (If death occurred in a hospital or institution, give its name instead of street and number.))

2. FULL NAME

Jas. Allen McDonald

(a) Residence. No.

St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Jan. 9 - 1926

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Coeur d'Alene, Idaho

10 NAME OF FATHER

Jas. McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country)

St. Mary, Mich.

12 MAIDEN NAME OF MOTHER

Margaret Hume

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

St. Mary, Mich.

14

Informant (Address)

James McDonald
Coeur d'Alene, R.I.

15

Filed

Feb. 6, 1926

W.D. Drama

Registrar

MEDICAL CERTIFICATE OF DEATH

1898

16 DATE OF DEATH

Jan 9

(Day)

1926 (Year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? none

(Signed) W.H. Holder, M. D.

Jan 11, 1926 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Forest Cem. Coeur d'Alene

1-11 1926

20. Undertaker

Address

Carstedt

Coeur d'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household, only not paid Housekeepers, who receive a definite salary, may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.). For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

168-219 028-219
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
FEB 10 1926
CERTIFICATE OF BIRTH

S

County of Kootenai
City of Coeur d'Alene
No. _____ St. _____ Registration District No. 30 File No. 138313
Hospital _____ Primary Registration District No. 1051 Registered No. 1494
FULL NAME OF CHILD Grace Mary Johnson
(Certificate of no value without full name of child.)

Sex of Child <u>7</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Jan. 19</u> 192 <u>6</u> (Month) (Day) (Year)
-----------------------	------------------------------	-----	--------------------------------	-----------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth _____

FATHER		MOTHER	
FULL NAME	<u>Clifton B. Johnson</u>	FULL MAIDEN NAME	<u>Grace M. Baird</u>
RESIDENCE	<u>Coeur d'Alene, Ida.</u>	RESIDENCE	<u>Coeur d'Alene, Ida.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>24</u> (Years)	AGE AT LAST BIRTHDAY	<u>24</u> (Years)
BIRTHPLACE	<u>Oregon</u>	BIRTHPLACE	<u>Oregon</u>
OCCUPATION	<u>Saw mill laborer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 4 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) John Oliver

(Physician or midwife)

Give names added from a supplemental report.

Address Coeur d'Alene, Ida.

Filed Feb. 8 1926 D. D. Brennan

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 52101

PLACE OF DEATH

FEB 10

CERTIFICATE OF DEATH

County of Kootenai Registration District No. 30
City of Coeur d'Alene Primary Registration District No. 1051

Local Registrar's No. 1439

(No. _____)
Death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Mary Johnson

(a) Residence. No. 702 - Indiana St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1 - 19 / 1926

7 AGE Years Months Days 1 If LESS than day, hrs. or min. 0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

10 NAME OF FATHER Clifton B. Johnson

11 BIRTHPLACE OF FATHER (city or town) Portland, Ore.
(State or country)

12 MAIDEN NAME OF MOTHER Grace M. Baird

13 BIRTHPLACE OF MOTHER (city or town) Portland, Ore.
(State or country)

14 Informant E. B. Johnson
(Address) 702 Indiana ave

15 Filed Feb 6, 1926 H. D. Drenna
Registrar

MEDICAL CERTIFICATE OF DEATH

189

16 DATE OF DEATH

Jan. 19 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1926, to Jan. 19, 1926.
that I last saw him alive on _____, 19____,
and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum
Stillborn
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John O. Wood, M. D.
Jan. 19, 1926 (Address) Coeur d'Alene
Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Forest Cem. Coeur d'Alene 1 - 26 1926

20. Undertaker

Address

C. Carney Coeur d'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc. without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

819 402 331 125
PLACE OF BIRTH

RECEIVED
FEB 3
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

138335

County of Lewiston
City of Winchester
No. 50 St. Registration District No. 50 State File No. 4
Hospital 217 Primary Registration District No. 217 Local Registrar's No. 4
FULL NAME OF CHILD Phil Born

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? — and { Number in order of birth — Legiti- mate? yes Date of birth Jan - 2 1926
(Month) (Day) (Year)

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth Two Number of child of this mother now living, including present birth One

FATHER
FULL NAME Arthur Roland Hart
RESIDENCE Winchester Ida
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Colorado
OCCUPATION Wagon House Man

MOTHER
FULL MAIDEN NAME Fettie Florence Cebal
RESIDENCE Winchester Ida
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Wash
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 2459 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) John J. Gias

(Physician or midwife)

Address Winchester Ida

Filed 17

1926

Registrar.

Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
FEB 3 1926
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 52128Local Registrar's No. 2

PLACE OF DEATH

County of Lemhi
City of Winchester

Registration District No. 30
Primary Registration District No. 214
(No. _____)

If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Steele Born

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan - 2 - 1926

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Winchester Idaho
(State or country)

10 NAME OF FATHER

Arthur Roland Hart11 BIRTHPLACE OF FATHER (city or town)
(State or country)Colorado

12 MAIDEN NAME OF MOTHER

Jettie Florence Abel13 BIRTHPLACE OF MOTHER Wash (city or town)
(State or country)14 Informant Arthur Hart(Address) Payson, Idaho15 Filed Jan 7, 1926Registrar P. E. Duval

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan - 2 - 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan - 2 - 1926 to Jan 2 - 1926
that I last saw him alive on Jan - 2 - 1926
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Steele Born

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Cholera
(Secondary) infection
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? no(Signed) John F. Gial, M. D.Jan - 2 - 1926 (Address) Winchester, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Crematorium Jan 3 1926
20. Undertaker Address Arde Chris

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Oneida FEB 5 1926
City of Molokai BUREAU OF VITAL STATISTICS
No. 77 114 036 444 St. Registration District No. 26 State File No. 138387
Hospital _____ Primary Registration District No. 2069 Local Registrar's No. 6

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ Legiti- mate? Yes Date of birth 1-14 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME

Frank A. Good.

RESIDENCE

Molokai.

COLOR

White

AGE AT LAST BIRTHDAY 36
(Years)

BIRTHPLACE

Utah.

OCCUPATION

Farmer.

MOTHER
FULL MAIDEN NAME

Sarah Dudley

RESIDENCE

Molokai.

COLOR

White

AGE AT LAST BIRTHDAY 37
(Years)

BIRTHPLACE

Molokai.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive { at 1:30 P M.
on the date above stated. { Stillborn

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

J. M. Kenna

(Physician or midwife)

Address

Molokai, Ida

Filed

1/31 1926

Registrar.

Registrar.

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE
NEW YORK 17, N. Y.

(THE BUREAU OF INVESTIGATION)

Property Registration District No. 1
Registration District No. 1

CALL TO ORDER

SECRET

1970 in a new collection published in 1977

LEATHER

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1957A01720

ИЗДАНИЕ 1992

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

10/11/54

I hereby certify that I attended the birth of this child, who was the male above stated.

When there was no lightning divider or lightning rod on the building, the lightning should make this return path. It is one thing to say that lightning should not strike a building, but it is another thing to say that lightning should not strike a building which has a lightning divider or lightning rod on it.

284THA

INTJ2192H

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Oneida*City of *Malad*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

FEB 5 1926

BUREAU OF VITAL STATISTICS

Registration District No. *2069*Primary Registration District No. *2069*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *52180*Registered No. *1*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Still born

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Child
(Write the word.)

6. DATE OF BIRTH

Jan - 14
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Malad Ida.

10. NAME OF FATHER

Frank F. Esgood

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Carah Dudley

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank F. Esgood

(Address)

Malad Ida

15.

Filed *1/31* 19*26**J. M. Kerns*
Local Registrar

16. DATE OF DEATH

1 - 14 19*26*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1 - 14 19*26* to *1 - 14* 19*26*that I last saw him alive on *still born*, 19*26*and that death occurred on the date stated above, at *—* M.

The CAUSE OF DEATH* was as follows:

Placenta previa, Child had been dead about 48 hrs. when delivered

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Kerns M. D.*1/14* 19*26* (Address) *Malad Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Ida *Jan. 15, 1926*

20. UNDERTAKER

ADDRESS

J. Guy Benson *Malad Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC AFFAIRS

OFFICE OF THE REGISTRAR

County of Camden

City of Molokai

No. 551-121036-415

St.

Registration District No. 2069

State File No. 118392

Hospital

Primary Registration District No. 2069 Local Registrar's No. 11

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>1 - 21 - 1926</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth <u>1</u>	
FULL NAME <u>Leah Egan</u>	FATHER	FULL MAIDEN NAME <u>Ella Daniels</u>	MOTHER
RESIDENCE <u>Arbon Idh</u>		RESIDENCE <u>Arbon Idh</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Danvers Idh</u>		BIRTHPLACE <u>Molokai</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive { 9:30 P. M.
on the date above stated. { Stillborn {

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. , 1926

(Signature) J. M. Turner
J. M. W.
(Physician or midwife)

Address Molokai Idh
Filed 51 1926 J. M. Turner
Registrar. Registrar.



FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Grande*
City of *Malad*

RECEIVED

FEB 5

BUREAU OF VITAL
STATISTICSDistrict No. *26*Registration District No. *2069*

St.)

File No. *3*Registered No. *3*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Child, John

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Child*
(Write the word.)

6. DATE OF BIRTH

Jan. 21 19*26*
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Malad Ida.

10. NAME OF FATHER

Leslie Evans

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ella Daniels

13. BIRTHPLACE OF MOTHER

(State or Country)

Malad Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leslie Evans

(Address)

15.

Filed *1/31* 19*26**J. M. Kern*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 21 19*26*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 21 19*26*, to *16 Jan 21* 19*26*
that I last saw him alive on *Jan 21* 19*26*and that death occurred on the date stated above, at *Malad* M.

The CAUSE OF DEATH* was as follows:

Premature birth at 8 mos. Breech. Delivery during delivery.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Kern M. D.*1/21 1926* (Address) *Malad Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Ida. *Jan 22 1926*

20. UNDERTAKER

ADDRESS

J. Guy Benson *Malad Ida.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

551-201-042813

County of.....

City of.....

No.....

Hospital.....

St.....

District No.....

Primary Registration District No.....

State File No.....

Local Registrar's No.....

CERTIFICATE OF BIRTH 138450

FULL NAME OF CHILD.....

(Certificate of no value without full name of child.)

Sex of Child <i>Female</i>	Twin <i>Single</i> and Triplets <i>Single</i> or other <i>Single</i>	Number in order of birth <i>2nd</i>	Legitimate? <i>Yes</i>	Date of birth <i>1 Jan</i> 1926 (Month) (Day) (Year)
----------------------------	--	-------------------------------------	------------------------	---

What bactericidal solution was used in eyes? *None*Number of child of this mother, including present birth *2nd*Number of child of this mother now living, including present birth *One*

FULL NAME

FATHER

Victor Masters

RESIDENCE

Buhl, Ida

COLOR

White

AGE AT LAST BIRTHDAY

22 (Years)

BIRTHPLACE

Springville, Utah

OCCUPATION

Housewife

FULL MAIDEN NAME

MOTHER

RESIDENCE

Buhl, Ida

COLOR

White

AGE AT LAST BIRTHDAY

25 (Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Stillborn* at *12:05* a.m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *J. H. Mac Manus*

(Physician or midwife)

Give names added from a supplemental report.

Address *Buhl, Ida*Filed *1-2*

1926

Registrar *J. H. Mac Manus*

Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. H.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/BJS

CHILD NAME OF CHILD

Sex of child	Age of child	Weight of child	Height of child	Date of birth	Place of birth

What postnatal condition was noted in eyes? _____
 What postnatal condition was noted in mouth? _____
 What postnatal condition was noted in skin? _____

FATHER		MOTHER	
NAME	NAME	NAME	NAME
RESIDENCE	RESIDENCE	RESIDENCE	RESIDENCE
COLOR	COLOR	COLOR	COLOR
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
BIRTHPLACE	BIRTHPLACE	BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION	OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____

When there was no attending physician or midwife, then the father, mother, etc., should make this report. A stillborn child is one that neither breathing nor shows other evidence of life at birth.

(Give names and titles of a supplemental report.)

Address _____

Signature _____

Date _____

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 52230
Registered No.

1. PLACE OF DEATH

County of Blaine Registration District No. 39
City of Boise Primary Registration District No. 2087 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Daisy Masters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White (Write the word.)

6. DATE OF BIRTH

Jan 1 1916
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Victor Masters

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Helvia Hale

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Victor Masters

(Address) Boise

15.

Filed 1-1 1916 J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

birth 19..... to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stillbirth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. MacMurray M. D.

19..... (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
not at place of death?

former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Boise Cemetery

DATE OF BURIAL

1-1 1925

20. UNDERTAKER

Howell & Co.

ADDRESS

Boise, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
165 124 342 291
County of Twin Falls

City of Twin Falls

No. _____ St. _____ Registration District 37 State File No. _____

Hospital County Primary Registration District No. 2025 Local Registrar's No. _____

FULL NAME OF CHILD James Mitchell James

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>1-24</u> <u>1926</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? Argyrol 10%

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Louis Reginald James
RESIDENCE Feed apt. Twin Falls Idaho
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Springfield Ill.
OCCUPATION Miner

MOTHER
FULL MAIDEN NAME Rose Ethel Brandt
RESIDENCE Feed apt. Twin Falls Idaho
COLOR White AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Salina Kansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9 16 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) S. H. Alexander

(Physician or midwife)

Address Twin Falls Ida

Filed Feb 1926 John F. Houghlin

Registrar.

Registrar.

1. The child was born at the residence of the mother, who was a native-born white female, aged 28 years, at the time of birth. The child was born at the residence of the mother, who was a native-born white female, aged 28 years, at the time of birth.

PLACE OF BIRTH

County of *Franklin*
 City of *Franklin*

DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. *37* of Registration District No. *108*
 Primary Health District No. *108* Local Registrar's No. *108*

Full Name of Child *John Henry*
 Sex *Male*
 Date of Birth *March 10, 1908*
 Time of Birth *10:30 A.M.*
 Place of Birth *Home of Mother*
 Name of Mother *John Henry*
 Name of Father *John Henry*
 Name of Mother *John Henry*
 Name of Father *John Henry*

What antiseptical solution was used in case of *None*
 Number of child of this mother, including present birth *1*
 Number of child of this mother, now living, including present birth *1*

Full Name of Child *John Henry*
 Sex *Male*
 Date of Birth *March 10, 1908*
 Time of Birth *10:30 A.M.*
 Place of Birth *Home of Mother*
 Name of Mother *John Henry*
 Name of Father *John Henry*
 Name of Mother *John Henry*
 Name of Father *John Henry*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *born* on the date above stated.

When there was no attending physician or midwife, then the father, householder, or another make this report. A statement is one that neither prescribes nor gives names added from a supplemental report.

(Signature) *John Henry*
 Address *John Henry*
 City *Franklin*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
FEB 9 1926
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

52221

State File No.

Local Registrar's No.

PLACE OF DEATH

County of Tom Falls
City of Tom Falls
Registration District No. 37
Primary Registration District No. 1085

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lewis Mitchell James

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) Jan 24-1926

7 AGE Years Months Days 1 If LESS than day, hrs. or min. ✓ ✓ ✓ ✓ 1 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Tom Falls Co. State Idaho

10 NAME OF FATHER Lewis P James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Id.

12 MAIDEN NAME OF MOTHER Rose Brandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Joplin Mo.

14 Informant Lewis P James
(Address) Tom Falls Rld Apts.

15 Filed Feb 1926 John F. Baughman
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 24th 19 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 24th to 9 26, 19 26,
that I last saw ✓ alive on Jan 24, 19 26,
and that death occurred, on the date stated above, at ✓ m.
The CAUSE OF DEATH* was as follows:

Still born - at 8th month of gestation.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholic intoxication
3 days previous (duration) yrs. mos. ds.

18 Where was disease contracted ✓
If not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None
(Signed) S. Hoff & Audrey M. D.

1/27/26, 19 26 (Address) Tom Falls Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Tom Falls Date of Burial Jan 25 1926

20. Undertaker Paul Beer 5221 Tom Falls,

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

279 230035-613
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED
FEB 12 1926

CERTIFICATE OF BIRTH

138552

County of Nez Perce
City of Lewiston
No. _____ St. _____ Registration District No. 96 File No. _____
Hospital St. Joseph's Primary Registration District No. 1009 Registered No. _____
FULL NAME OF CHILD Elvise Spivey

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Jan. 30 1926</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth. 3rd Number of child of this mother now living, including present birth. 1

FATHER		MOTHER	
FULL NAME	<u>Wm. A. Spivey</u>	FULL MAIDEN NAME	<u>Daisy Walker</u>
RESIDENCE	<u>Spalding, Idaho</u>	RESIDENCE	<u>Spalding, Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>34</u> (Years)	AGE AT LAST BIRTHDAY	<u>32</u> (Years)
BIRTHPLACE	<u>Washington</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born, at 4:10 P. M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. J. Brannon

(Physician or midwife)

Give names added from a supplemental report.

Address Lewiston, Idaho

Filed Feb 10 1926 Susan E. Bruce

Registrar.

Registrar.

0-1000
 FOR PUBLIC USE
 OF BUREAU OF
 RECORDS AND ADMINISTRATION
 UNITED STATES DEPARTMENT OF JUSTICE
 FEDERAL BUREAU OF INVESTIGATION
 FORM NO. 104 (Rev. 1-25-60)
 THIS FORM IS TO BE FILLED OUT BY THE INDIVIDUAL OR BY A PERSON HAVING KNOWLEDGE OF THE INDIVIDUAL'S HISTORY. IT IS NOT TO BE FILLED OUT BY AN AGENCY OR BY A PERSON WHOSE DUTY IT IS TO MAINTAIN RECORDS OF THE INDIVIDUAL.

NAME (Last, first, middle) LAST FIRST MIDDLE NAME NAME NAME		SEX Male Female	
DATE OF BIRTH (Month, day, year) MONTH DAY YEAR		PLACE OF BIRTH (City, State, Country) CITY STATE COUNTRY	
SOCIAL SECURITY NUMBER NUMBER		MARITAL STATUS Single Married Divorced Widowed	
CURRENT ADDRESS (Street, City, State, Zip) STREET CITY STATE ZIP		PREVIOUS ADDRESS (Street, City, State, Zip) STREET CITY STATE ZIP	
OCCUPATION OCCUPATION		EDUCATION EDUCATION	
RELIGION RELIGION		RACE RACE	
MOTHER'S NAME (Last, first, middle) LAST FIRST MIDDLE NAME NAME NAME		FATHER'S NAME (Last, first, middle) LAST FIRST MIDDLE NAME NAME NAME	
DATE OF DEATH (Month, day, year) MONTH DAY YEAR		PLACE OF DEATH (City, State, Country) CITY STATE COUNTRY	
CAUSE OF DEATH CAUSE OF DEATH		BURIAL PLACE (City, State, Country) CITY STATE COUNTRY	
SIGNATURE OF INDIVIDUAL OR PERSON KNOWING INDIVIDUAL SIGNATURE		DATE DATE	

OFFICE OF ATTENDING CLERK OF DISTRICT COURT
 DISTRICT OF COLUMBIA
 WASHINGTON, D.C. 20540

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Prank Cook

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

52164

State File No.

PLACE OF DEATH
County of Lewiston
City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Spivey

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 30-26

7 AGE Years Months Days 1 If LESS than day hrs. or min. but

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston Ida
(State or country)

10 NAME OF FATHER W. R. Spivey

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country)

12 MAIDEN NAME OF MOTHER Daisy Walker

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant W. R. Spivey
(Address) Shelding St.

15 Filed Feb 9, 1926 Susan E. Bruce
Registrar

RECEIVED

FEB 12

BUREAU OF VITAL

(If death occurred in a hospital or institution, give city or town and State)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 30 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1926, to Jan 30, 1926.
that I last saw her alive on Jan 30, 1926.
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born
atelectasis

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dr. B. B. B. B. B., M. D.
Feb 1, 1926 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial 2/1 1926

20. Undertaker Vassaro Address Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

243 227035 493
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Nez Perce RECEIVED

City of Lewiston FEB 12

CERTIFICATE OF BIRTH 138554

No. St. Joseph District No. 96 File No. 138554

Hospital St. Joseph Primary Registration District No. 1019 Registered No. 138554

FULL NAME OF CHILD Baby Kucklick
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Jan 27</u> 192 <u>6</u> (Month) (Day) (Year)
----------------------------	--	-----	--------------------------------	-----------------------------	---

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FULL NAME <u>A. J. Kucklick</u>	FATHER	FULL MAIDEN NAME <u>Georgia Miller</u>	MOTHER
RESIDENCE <u>Pomeroy</u>		RESIDENCE <u>Pomeroy</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Germany</u>		BIRTHPLACE <u>Minnesota</u>	
OCCUPATION <u>Salesman</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was at M.
on the date above stated. (Pen or ink stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) O. O. Corrao

(Physician or midwife)

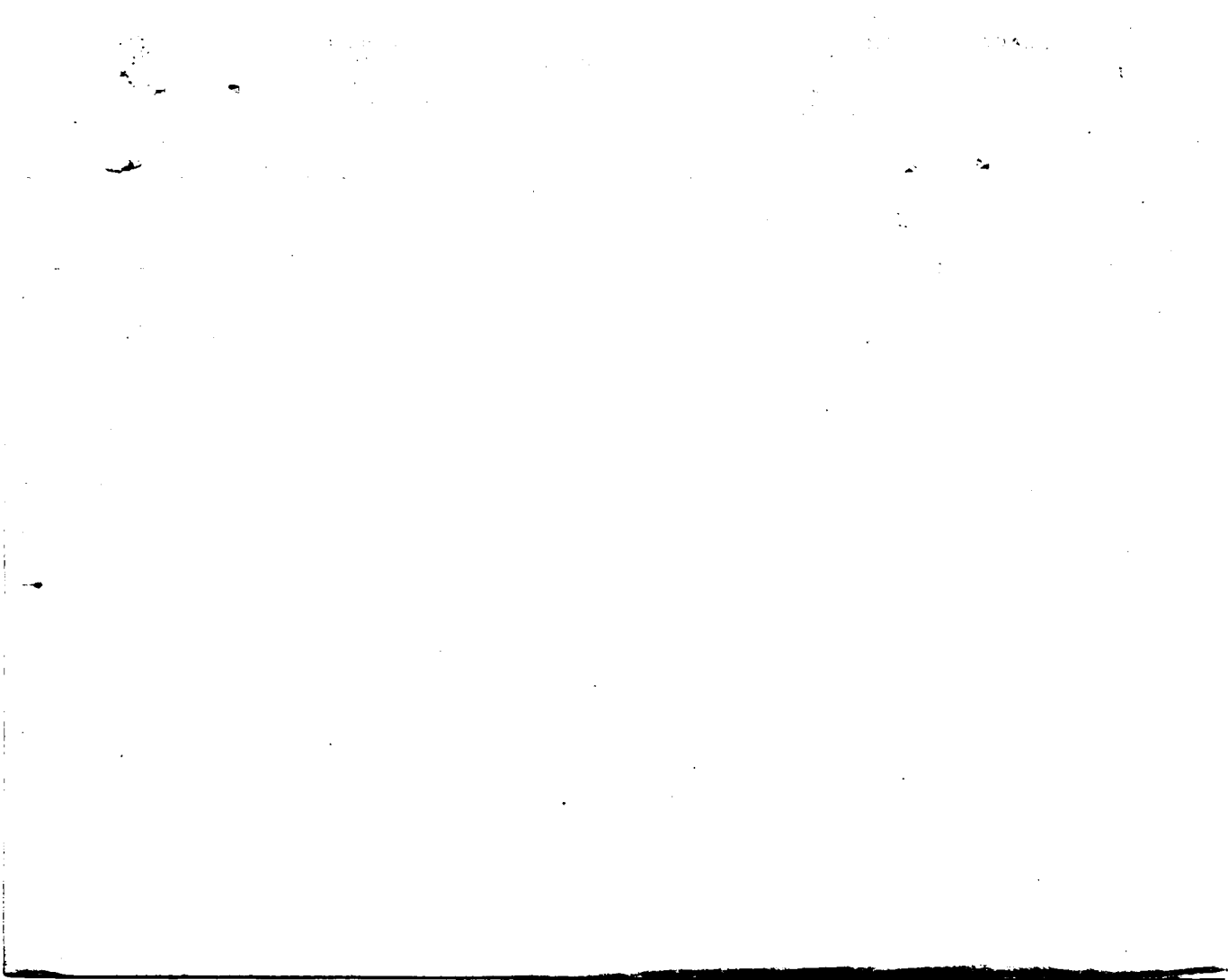
Give names added from a supplemental report.

Address Lewiston Ida

Filed Feb 10 1926 Susan E. Miller

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. A. Joseph Hospital St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 52166

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Kucklick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH.

Jan 27 1916
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

None

9. BIRTHPLACE

(State or Country)

St Josephs Hosp Idaho

10. NAME OF FATHER

A T Kucklick

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Georgia Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed Feb 9 1916

Sam E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

RECEIVED

16. DATE OF DEATH

about FEB 12 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1916, to Jan 27 1916, that I last saw him alive on Jan 27 1916, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

I don't know

(Duration) Yrs. mos. ds.

Contributory (Secondary)

same death(Signed) M. D.19. (Address) Marion Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death...yrs...mos...days In the State...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Corner WashJan 28 1916

20. UNDERTAKER

ADDRESS

A. F. KucklickCommunity

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
662 104003 296
County of _____
City of _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED

FEB 15 1926

CERTIFICATE OF BIRTH 138663

No. 56719 St. Registration District No. 58 State File No. _____
Hospital _____ Primary Registration District No. 216 Local Registrar's No. 749

FULL NAME OF CHILD Ronald Brown Foster
(Certificate of no value without full name of child)

Sex of Child m Twin Triplet or other? } and { Number in order of birth } Legitimate? Yes Date of birth Jan 4 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 20% Ph. S. L. Sol.

FATHER		MOTHER	
Number of child of this mother, including present birth	1	Number of child of this mother now living, including present birth	1
FULL NAME	Clinton Edwin Foster	FULL MAIDEN NAME	Lorena E Brown
RESIDENCE	516 N 9th Pocatello Ida	RESIDENCE	516 N 9th Pocatello Ida
COLOR	26	COLOR	26
AGE AT LAST BIRTHDAY	23 (Years)	AGE AT LAST BIRTHDAY	25 (Years)
BIRTHPLACE	Salt Lake City Utah	BIRTHPLACE	Pocatello Ida
OCCUPATION	Cornman O.S.D.	OCCUPATION	housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 712 3/4 P. M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) _____

(Physician or midwife)

Address _____

Filed _____ 1926 _____

Registrar.

Registrar.

STATE OF TEXAS
 COUNTY OF DALLAS
 DEPARTMENT OF HEALTH

RECEIVED

Date of birth

Child's name

(Certificate of no value without full name of child)

Date of birth
 Birth
 (Month)

Sex
 Male
 Female

Weight
 Height
 Color of hair
 Color of eyes
 Color of skin
 To be answered only in case of special finding

Where investigation was made in case of

Number of child of mother now living, including deceased

MOTHER

Child's name
 Name
 Name

Residence

Color

Age at last birthday

Birthplace

Occupation

Age at last birthday

Color

Birthplace

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on

(Signature)

(Physician or midwife)

Address

Signed

When there was no attending physician or midwife, then the father, grandmother, etc. should make a return, although it is not a legal document, nor should it be used as evidence in any court. The parent should sign a statement report.

IDAHO DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of IDAHO } ss. B 25 11 32 AM '77 Certificate No. 138663
County of BINGHAM }

The undersigned does solemnly swear that certain facts on the certificate of birth
for Unnamed Foster (Male) who was born on Jan 4, 1926
(Name on Original Certificate) (Was Born or Died) (Date of Event)
in Pocatello, Idaho (Bannock) are erroneous or were omitted; and that, to the best of his knowledge, the
(Place of Event)
true facts are shown by prepared on are:

FACTS TO BE CORRECTED
("Name," "Birth Date," "Cause of Death," Etc.)
child's name

FROM
(As on Original)
Unnamed

TO
(The Correct Facts)
Ronald Brown Foster

Subscribed and sworn to before me this 24th day of
February, 1977
Lynn Warner
Notary Public, residing at Aberdeen
My commission expires 7-7-78
(Seal)

Signed Liam M. Wallace
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)
Aberdeen, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of IDAHO } ss.
County of BINGHAM }

[This Affidavit **MUST** Also be Executed.
(See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 24th day of
February, 1977
Lynn Warner
Notary Public, residing at Aberdeen
My commission expires 7-7-78
(Seal)

Signed Earl W. Penhatch
(Signature of Any Credible Person)
Aberdeen, Idaho
(Street Address, City, State)

Rush

Certif of Baptism and Confirmation from the LDS Church gives nameas ~~Ron~~ Ronald Brown Foster son of Claxton E. Foster and Lorena E. Brown Born Jan 4, 1926 at Pocatello, Idaho. Baptized Jan 6, 1934. viewed by V. S.

FEB 28 1977

Certif of Blessing from the LDS Church gives nameas Ronald Brown Foster son of Claxton E. Foster and Lorena Ellen Brown. born Jan 4, 1926 at Pocatello, Idaho Blessed Feb 7, 1926. viewed by V. S.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

816 104 043-795

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonanza

City of Pocatello

FEB 15 1926

BUREAU OF VITAL

CERTIFICATE OF BIRTH 138664

No.

St.

~~STATISTICS~~

District No.

28

State File No.

Hospital Poe Gen

Primary Registration District No. 2161

Local Registrar's No. 7420

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child M

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate? Yes

Date of
birth Jan 4

(Month)

(Day)

(Year) 1926

What bactericidal solution was used in eyes? 2.0% Argrol

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

Gordon W. Kewkes

RESIDENCE

COLOR Br

AGE AT LAST
BIRTHDAY 25

(Years)

BIRTHPLACE Reynolds Ida

OCCUPATION Carpenter

FULL
MAIDEN
NAME

MOTHER

Nora Crumley

RESIDENCE 225 Bridge

COLOR Br

AGE AT LAST
BIRTHDAY 30

(Years)

BIRTHPLACE Hemlock Ark

OCCUPATION House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at Steel Creek on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address Pocatello

Filed 21

1926

Registrar.

Registrar.

RECEIVED
FEB 16

CERTIFICATE OF BIRTH

STATE OF VIRGINIA

County of ...

Birth of ...

(Certificate of no value without this seal of child)

Full Name of Child

Parents

What name was given to child?

Number of child of this mother, including present birth

Full Name of Mother

Residence

Color

Birthplace

Age at last birthday

Occupation

Signature of Physician or Midwife

Back of ...

Birth of ...

Address

Filed

...

...

...

...

...

...

...

...

When there was no attending physician, the birth of the child should be reported to the nearest health officer, who should make the report to the health officer of the county.

...

...

...

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
JAN 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 51981

PLACE OF DEATH

JAN 19

CERTIFICATE OF DEATH

County of Bannock Registration District No. 28

City of Poratillo Primary Registration District No. 2761

Local Registrar's No. 4227

(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Infant Hawker

(a) Residence. No. 225 West Bridge St.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) January 4 - 1926

7 AGE Years Months Days Stillborn 1 day, LESS than hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poratillo
(State or country) Idaho

10 NAME OF FATHER E. W. Hawker

11 BIRTHPLACE OF FATHER (city or town) Payson Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Norma Grumley

13 BIRTHPLACE OF MOTHER (city or town) Arkansas
(State or country)

14 Informant E. W. Hawker
(Address) Poratillo

15 Filed 1-4, 1926 J. J. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 4 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
that I last saw h_____ alive on _____, 19____.
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Q. T. Call M.D.
(Signed) 1/4/26, 19____ (Address) Poratillo, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Mountain View Bur Date of Burial Jan 4 1926

20. Undertaker Schumacher & Hall Address Poratillo

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

24946 003-466
PLACE OF BIRTH

County of Bannock **RECEIVED** **DEPARTMENT OF PUBLIC WELFARE** **BUREAU OF VITAL STATISTICS** **S**
City of Pocatello **FEB 15** **CERTIFICATE OF BIRTH** **138681**
No. _____ St. Registration District No. 28 State File No. _____
Hospital ✓ Primary Registration District No. 2161 Local Registrar's No. 7437
FULL NAME OF CHILD Baby Burton
(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Jan 16 1926</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Marion B. Burton</u>	<u>Pocatello Idaho</u>	<u>Opal Downing</u>	<u>same</u>
COLOR <u>wh</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)	COLOR <u>wh</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Pocatello Idaho</u>		BIRTHPLACE <u>Blackfoot Idaho</u>	
OCCUPATION <u>R.R. Fireman</u>		OCCUPATION <u>wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1:10 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) D C Ray

(Physician or midwife)

Address Pocatello Idaho

Filed 21 1926

Registrar.

Registrar.

RECEIVED
 COMMUNICATE TO THE
 DIRECTOR

Primary Registration Number No. 11000111

DATE OF BIRTH: 11/11/11
 PLACE OF BIRTH: [illegible]
 SEX: [illegible]
 RACE: [illegible]
 COLOR: [illegible]

NAME OF BIRTH MOTHER: [illegible]
 NAME OF BIRTH FATHER: [illegible]

RESIDENCE: [illegible]
 COLOR: [illegible]

BIRTH DATE: [illegible]
 BIRTH PLACE: [illegible]
 OCCUPATION: [illegible]

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was born on [illegible] at [illegible]

(Signature)
 [illegible]

(Position of Registrar)
 [illegible]

THIS IS A COPY OF THE ORIGINAL RECORD OF THE BIRTH OF THIS CHILD. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
FEB 15 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
STATISTICAL CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 52313

PLACE OF DEATH
County of Bannock Registration District No. 28
City of Poratella Primary Registration District No. 2161
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4725

2. FULL NAME Infant Burton

(a) Residence. No. 756 - North Fairfield St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) January 16 - 1926

7 AGE Year Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poratella
(State or country) Idaho

10 NAME OF FATHER Francis G. Burton

11 BIRTHPLACE OF FATHER (city or town) Poratella Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Opal Downing

13 BIRTHPLACE OF MOTHER (city or town) Blackfoot Idaho
(State or country)

14 Informant Francis G. Burton
(Address) Poratella

15 Filed 1-16 1926 H. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 16 19 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to 1-16- 1926.

that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Still born full term
umbilical cord caught
on pin. Stopped circulation
and 20 hours before birth
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) D. C. Ray M. D.
1-16 1926 (Address) Poratella

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Mountain View Cemetery Date of Burial Jan 16 1926
20. Undertaker Schumacher & Hall Address Poratella

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
415 117 803 712
County of Bannock
City of Pocatello
No. ✓ St. Registration District No. 28 State File No. 138684
Hospital Poor General Primary Registration District No. 2161 Local Registrar's No. 7440
FULL NAME OF CHILD Stillborn

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
FEB 15 1917
BUREAU OF VITAL STATISTICS

S

Sex of Child Male Twin Triplet or other? ✓ and { Number in order of birth } Legitimate? yes Date of birth Jan 17 1916
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER		MOTHER	
FULL NAME	<u>Robert Eli Manning</u>	FULL MAIDEN NAME	<u>Carrie Dorothea Gasser</u>
RESIDENCE	<u>Pocatello Idaho</u>	RESIDENCE	<u>same</u>
COLOR	<u>wht</u>	COLOR	<u>wht</u>
AGE AT LAST BIRTHDAY	<u>45</u> (Years)	AGE AT LAST BIRTHDAY	<u>44</u> (Years)
BIRTHPLACE	<u>Iowa</u>	BIRTHPLACE	<u>Iowa</u>
OCCUPATION	<u>Merchant</u>	OCCUPATION	<u>wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 8: am on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. May

(Physician or midwife)

Address Pocatello Idaho

Filed 71 1917 Registrar.

Registrar.

and the number of cases in order to find out whether the number of cases is increasing or decreasing. It is, of course, not possible to find out whether the number of cases is increasing or decreasing without knowing the number of cases in the past.

10-10-41

shows that evidence of the great

SECRET

1. I was not aware of the fact that I was being interviewed.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

CONFIDENTIAL

32A. JAH-TSUNG

SECRET

TRAITA 3DA
YACHTING

(b)(7)(D)

DISPATCH

REJOY

● 2010年10月1日

我輩何人可

EMAN

**JOHN
HARRIS**

PHOTOM

Number of days of the month in which the work was done

Subject to be killed by the mother and her children

WYATT INDUSTRIES, INC.

1942

SECRET
Strategic and

to be made
to be made
to be made

• When I
I can't

10-10-68

It is to be noted that the following information is confidential and should be handled accordingly.

WELCOME TO MY LIFE

Registration District 70

10/10/1944

12-11-68

61957

UNITED STATES GOVERNMENT

SEALING DEATH

REPLY TO THE GOVERNMENT OF THE UNITED STATES OF AMERICA
IN WASHINGTON, D.C.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BarnesCity of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

FEB 15 1926

BUREAU OF VITAL STATISTICS

(No. 100 Gen Thas St.)Registration District No. 28Registration District No. 2141STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 52317Local Registrar's No. 100

If death occurred in hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE & SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale white Single

5. DATE OF BIRTH

Jan 17 1926
(Month) (Day) (Year)

7. AGE

Still born
IF LESS than 1 day how many
Yrs. Mos. ds. hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Pocatello, Ida

10. NAME OF

Father

R. E. Manning

11. BIRTHPLACE

OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME

OF MOTHER

Carrie Gasser

13. BIRTHPLACE

OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. E. Manning
Pocatello, Ida

15.

Filed

Jan 18 1926

Manning
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 17 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 19 to Jan 17 1926

that I last saw h. alive on 19

and that death occurred on the date stated above, at 8:20 A.M.

The CAUSE OF DEATH* was as follows:

Premature separation
of placenta

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1/18 1926 (Address) Pocatello, Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello, Ida Jan 18 1926

20. UNDERTAKER

ADDRESS

McDonnell & Co. Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

385-22005-318
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Benewah FEB 19 1916
City of St. Maries BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH 138731
No. 32 St. Registration District No. 32 State File No. 138731
Hospital St. Maries Primary Registration District No. 3049 Local Registrar's No. 5
FULL NAME OF CHILD Vergil Cheney
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? ✓ and { Number in order of birth 1 } Legitimacy Yes Date of birth Jan 22 1916
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>James Cheney</u>	<u>St. Maries, Idaho</u>	<u>Glice Lahaie</u>	<u>St. Maries, Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Montana</u>	OCCUPATION <u>Logger</u>	BIRTHPLACE <u>Idaho</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5:50 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Caroline Rhys

(Physician or midwife)

Address St. Maries, Ida

Filed Jan 10 1916 Osmerow

Registrar.

Registrar.

STATE OF TEXAS
DEPARTMENT OF PUBLIC SAFETY
BUREAU OF VITAL STATISTICS

RESEARCH

OFFICE OF THE ATTORNEY GENERAL

State -

Exhibit A Registration District No. 1-100

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

Page 10 of 10

...and ...

MO

(continued)

2017

AT LAST
BIRTHDAY

OCCUPATION

MEMORANDUM FOR THE DIRECTOR, FBI

... ..

100

(Signature) _____

100-443887-100

SECRET

REF ID: A66087

1

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

FEB 19

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Bannock*City of *St. Maru*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Vergil Cheney*District No. *32*Primary Registration District No. *2049*(No. *St. Maru Hospital St.*)State File No. *52344*Local Registrar's No. *5*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Male**white**X*

(Write the word)

6. DATE OF BIRTH

*Jan**22**1926*

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1
day how manyhrs. or
min.?

Yrs.

Mos.

ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
(or employer)*B. E. X**X*

9. BIRTHPLACE

(State or Country)

10. NAME OF
Father*James M. Cheney*11. BIRTHPLACE
OF FATHER

(State or Country)

*Bannock Montana*12. MAIDEN NAME
OF MOTHER*Alice Lahaie*13. BIRTHPLACE
OF MOTHER

(State or Country)

Willis City N. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James M. Cheney

(Address)

St. Maru Ida.

15.

Filed

*Jan 23*19*26**Osburn*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH

*Jan**22*19*26*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1/22

to

*1/22*19*26*

that I last saw him alive on

and that death occurred on the date stated above, at *5 P. M.*

The CAUSE OF DEATH* was as follows:

*Stillborn due to
contracted pelvis and pro-
lapsed cord*

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*W. A. Roberts M. D.**28* 19*26*(Address) *St. Maru Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Woodlawn**Jan 24 1926*

20. UNDERTAKER

ADDRESS

*Mitchell & Menzies**St. Maru Ida.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

291-217009-319
County of Bonner

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

City of Sandpoint **RECEIVED** MAR 5 1926 **CERTIFICATE OF BIRTH** 138834No. 707 Cedar St. Registration District No. 76 State File No. _____Hospital _____ Primary Registration District No. 2155 Local Registrar's No. _____FULL NAME OF CHILD Stillbirth (Brackett)

(Certificate of no value without full name of child)

Sex of Child <u>female</u>	Twins Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>yes</u>	Date of birth <u>2-17</u> 192 <u>6</u>
(To be answered only in event of plural births)			(Month) (Day) (Year)	

What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 3

FATHER	
FULL NAME	<u>T. H. Brackett</u>
RESIDENCE	<u>Samuels, Ida</u>
COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>31</u> (Years)
BIRTHPLACE	<u>Yakima, Wash.</u>
OCCUPATION	<u>Farmer</u>

MOTHER	
FULL MAIDEN NAME	<u>Mattie Larson</u>
RESIDENCE	<u>Samuels, Ida</u>
COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>32</u> (Years)
BIRTHPLACE	<u>Hennepin, Minn.</u>
OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at E. A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Sandpoint, Ida1926Viola Allen
Deputy Registrar.

Registrar.

SECRET

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BonnerCity of SandpointRegistration District No. 76
Bureau of Vital Statistics
Registration District No. 2150
State of IdahoFile No. 52363

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn (Braschetti)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Feb. 17 1926
(Month) (Day) (Year)

7. AGE

stillbirth
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Sandpoint, Ida.

10. NAME OF FATHER

T. W. Braschetti

11. BIRTHPLACE OF FATHER

(State or Country) Yakima, Wash.

12. MAIDEN NAME OF MOTHER

Mattie Larson

13. BIRTHPLACE OF MOTHER

(State or Country) Hennepin, Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. W. Braschetti
Sandpoint, Ida.(Address) Sandpoint, Ida.

15.

Filed Feb. 17 1926 Viola Allen
Deputy Local Registrar

16. DATE OF DEATH

About Feb. 8 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Fetus died in uterus
four days before full
term. Habitual - cause
unknown.
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. W. A. Smith M. D.2-17-1926 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Samuels, Ida. (rural) 2-17-1926

20. UNDERTAKER

ADDRESS

father - T. W. Braschetti Samuels, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

8-19712-876-813
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia
City of Burley Ida
No. _____ St. _____ Registr. STATISTONS 117 State File No. _____
Hospital. _____ Primary Registration District No. 2196 Local Registrar's No. 3307
FULL NAME OF CHILD Austin Dale Harwood
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>Yes</u>	Date of birth <u>Feb 12</u> , 19 <u>26</u> (Month) (Day) (Year)
--------------------------	---	-------	---	-----------------------------	---

What bactericidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth _____

FULL NAME <u>Austin W. Harwood</u>	FATHER	FULL MAIDEN NAME <u>Ruby Hale</u>	MOTHER
RESIDENCE <u>Burley Ida</u>		RESIDENCE <u>Burley</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Utah</u>		BIRTHPLACE <u>Oakley Ida</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 4:30 P.M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return.
A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) G. H. Coopers M.D.

Physician and Surgeon
(Physician or midwife)

Address Burley Ida

Filed 1926 D. J. C. Patterson

Registrar.

Registrar.

SECRET

1. Name of the person or organization to whom the letter is addressed.
2. Address of the person or organization to whom the letter is addressed.
3. City and State of the person or organization to whom the letter is addressed.
4. Date of the letter.
5. Subject of the letter.

SECRET

MADE IN JAPAN

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-19-2007 BY 60322 UCBAW

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-19-2007 BY 60322 UCBAW

10-10-68

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was born on _____ at _____
in _____ State.

I declare under penalty of perjury that the foregoing is true and correct.

SECRET

1945

54

REPORT A. C. WHITEHEAD, OF MILWAUKEE, IN THE INVESTIGATION OF THE
CAUSE OF THE FLOODING OF THE RIVER IN THE FALL OF 1907.

noD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

9557170161653
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

138916

County of Cassia

City of Burley

No. 1

Registration District No. 117
St. BUREAU OF VITAL

File No. 117

Hospital

Primary Registration District No. 2196

Registered No. 3319

FULL NAME OF CHILD Stellbornes

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth <u>1</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Feb 17</u> (Month) (Day) (Year) <u>1926</u>
--------------------------	---	-----	--	-----------------------------	--

What bacteriocidal solution was used in eyes? ly. W.

Number of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 8

FATHER
FULL NAME John Penner
RESIDENCE Burley
COLOR white AGE AT LAST BIRTHDAY 49 (Years)
BIRTHPLACE Mo.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Jessie Nelson
RESIDENCE Burley
COLOR white AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Mo.
OCCUPATION mother

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stellbornes 1130 a. m.
on the date above stated. (born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) J. A. Butler

(Physician or midwife)

Give names added from a supplemental report.

Address Burley, Idaho

Filed 3-1 1926 Dr. J. C. Patterson

Registrar.

Registrar.

10/10/10

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No.

Registration District No.

STATISTICS

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF

Father

11. BIRTHPLACE

OF FATHER

(State or Country)

12. MAIDEN NAME

OF MOTHER

13. BIRTHPLACE

OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

3-8

1926

By Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory

(Secondary)

(Duration)

hrs.

mos.

ds.

(Signed)

(Address)

M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

N. B.—In case of more than one child at birth, in order of birth stated each and the number of each.

249-101-23 353
 PLACE OF BIRTH Idaho MAR 4 1926
 County of Blaine BUREAU OF VITAL STATISTICS DEPARTMENT OF PUBLIC WELFARE
 City of Emmett BUREAU OF VITAL STATISTICS
 No. _____ St. Registration District No. 6 State File No. 38971
 Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____
 FULL NAME OF CHILD Thomas Smith
 (Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? yes Date of birth Mar 1 1926
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>Thomas Smith</u>	FULL MAIDEN NAME	<u>Catherine Telfer</u>
RESIDENCE	<u>Emmett 2da</u>	RESIDENCE	<u>Emmett</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>43</u> (Years)	AGE AT LAST BIRTHDAY	<u>41</u> (Years)
BIRTHPLACE	<u>Scotland</u>	BIRTHPLACE	<u>Scotland</u>
OCCUPATION	<u>Sheep Manager</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 1-30 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1926

Address Emmett 2da
 Filed 2-1- 1926
 Registrar. J. H. Reynolds

Ref: 100

Filed

Address

(Physician or midwife)

(Signature)

I hereby certify that I attended the birth of this child, who was
born on the _____ day of _____ at _____
and the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

OCCUPATION

BIRTHPLACE

COLOR

AGE AT LAST
BIRTHDAY

COLOR

BIRTHPLACE

OCCUPATION

RESIDENCE

RESIDENCE

NAME

FATHER

NAME

MOTHER

Number of child in this mother's family (including himself)

Number of child in this mother's family (including herself)

What medicinal solution was used in case

It is suggested only in special cases

DATE

AND

TIME

DATE

THIS IS A COPY OF THE

(Certificate of no value without this page of child)

Primary Registration District No.

Registration District No.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Idaho*City of *Emmett*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
MAR 1 1926
BUREAU OF VITAL STATISTICS
Registration District No. *6*
Primary Registration District No. *6*
(No. *Thomas Smith* St.)

F DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *52463*

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male**White**Infant*
(Write the word)

6. DATE OF BIRTH

*Mar 1**1**1926*

(Month)

(Day)

(Year)

7. AGE

New Born

Yrs.

Mos.

ds.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Catherine Telfer

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Smith

(Address)

Emmett Ida

15.

Filed

*Mar 1**1926**J. A. Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Mar**1**1926*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*at birth**19*

to

*19*that I last saw him alive on *still born* *19*and that death occurred on the date stated above, at *1229*

The CAUSE OF DEATH* was as follows:

Breath Presentative lost while trying to deliver head

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. A. Reynolds

M. D.

3/1 1926

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Emmett Ida**3/1 1926*

20. UNDERTAKER

ADDRESS

*W. Buckner**Emmett Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, "Foreman, "Manager, "Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers, who receive a definite salary,** may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**") **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia,**" unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, "Anaemia**" (merely symptomatic), "**Atrophy, "Collapse, "Coma, "Convulsions, "Debility, "Congenital, "Senile, etc., "Dropsy, "Exhaustion, "Heart Failure, "Hemorrhage, "Inanition, "Marasmus, "Old age, "Shock, "Uraemia, "Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "**Contributory.**"

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 239 225 029 239
County of Latah
City of Potlatch
No. _____ St. _____ District No. 65 State File No. 139063
Hospital Potlatch Primary Registration District No. 2145 Local Registrar's No. _____
FULL NAME OF CHILD Lilly Clara Strand
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth Jan 25 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Martin Strand
RESIDENCE Potlatch
COLOR White AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Norway
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Katherine Strand
RESIDENCE Potlatch
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Norway
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { born alive } at 10 A. M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

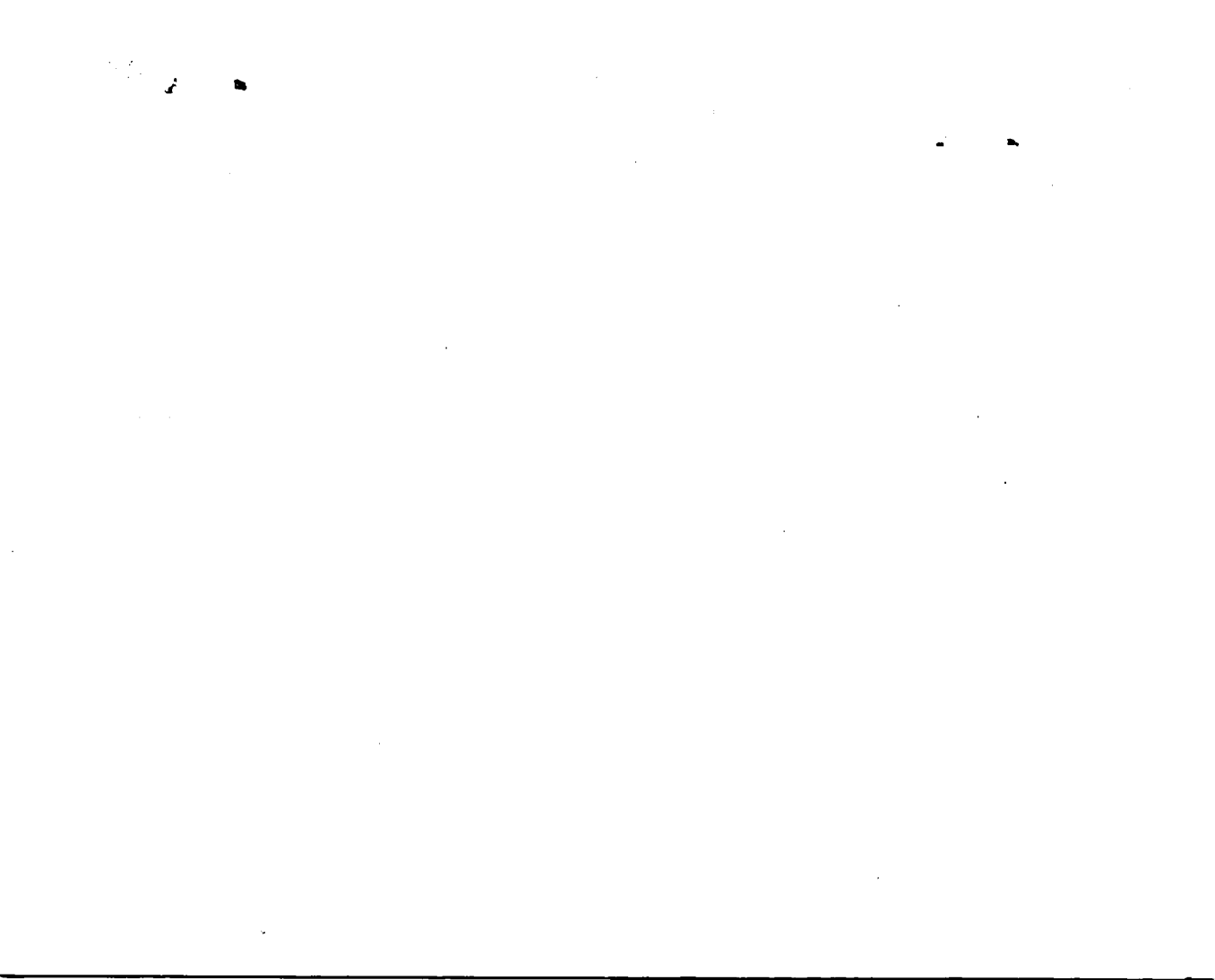
(Signature) D. F. Gibson

(Physician or midwife)

Address Potlatch

Filed Jan 25 1926 D. J. Thompson Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH. **RECEIVED** **CERTIFICATE OF DEATH.**
FEB 20 1926
 County of Latah Registration District No. 65
 City of Potlatch **BUREAU OF VITAL STATISTICS** Registration District No. 2145 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lilly Klara Strand

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 52508

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED.

Female White Single
 (Write the word.)

6. DATE OF BIRTH.

Jan 25 1926
 (Month) (Day) (Year)

7. AGE

Yrs. 0 Mos. 0 ds. 0

IF LESS than 1 day
 how many 0 hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Martin Strand

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Katherine Ranesen

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Martin Strand

(Address)

Potlatch

15.

Filed

Jan 25 - 1926

W. J. Thompson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jun 25 1926
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
191, to 191

that I last saw h. ✓ alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Injury at Birth in
Breach of presentation

(Duration) Yrs. 0 mos. 0 ds.

Contributory
 (Secondary)

Compression of cord.

(Duration) yrs. 0 mos. 0 ds.

(Signed)

F. C. Gibson M. D.

2/25/1926 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Potlatch
Washington

Jan 25 1926

20. UNDERTAKER

ADDRESS

E. Irwin

Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 5 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
MAR 5 BUREAU OF VITAL STATISTICS

BUREAU OF CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 52523

PLACE OF DEATH

County of Lewis
City of Winchester

Station District No. 50
Primary Registration District No. 2129
(No. _____)

Local Registrar's No. 10

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Shirley Boone

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) _____

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb-27-1926

7 AGE Years _____ Months _____ Days _____ 1 day, _____ hrs. _____ min.
Shirley Boone

8 OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Winchester Del.
(State or country)

10 NAME OF FATHER John P. Hoffman

11 BIRTHPLACE OF FATHER (city or town) Winconsin
(State or country)

12 MAIDEN NAME OF MOTHER Winifred Waite

13 BIRTHPLACE OF MOTHER (city or town) Winconsin
(State or country)

14 Informant John P. Hoffman
(Address) Winchester, Ida

15 Filed 27 1926 R. R. Doolittle
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb-27 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb-27, 1926, to Feb-27, 1926.
that I last saw him alive on Feb-27, 1926.
and that death occurred, on the date stated above, at 3:29 a.m.

The CAUSE OF DEATH* was as follows:
Shirley Boone

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) John F. East M. D.
Feb-27 1926 (Address) Winchester Del.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Winchester Del. Date of Burial Feb 27 1926

20. Undertaker H. R. Needham Address Charlottesville Va.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of *Payette*

City of *Fruitland*

No. *993125038-493*

St.

Registration

MAR 3

BUREAU OF VITAL

STATISTICS

CERTIFICATE OF BIRTH

39155

District No. *51*

State File No.

Hospital

Primary Registration District No. *2130*

Local Registrar's No. *7*

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

Feb. 25 1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth *1*

Number of child of this mother now living, including present birth *0*

FULL
NAME

FATHER

Lloyd D. Richardson

RESIDENCE

Fruitland Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

36

(Years)

BIRTHPLACE

Kaupar

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Jessie M. Dill

RESIDENCE

Fruitland Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

30

(Years)

BIRTHPLACE

Nebraska

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Stillborn* *3* A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

W. H. Keese, M.D.

(Physician or midwife)

Address

Ontario Oregon

Filed *2-26*

1926

Mrs. Wm. J. Freydale

Registrar.

Registrar.

3

~~SECRET~~

NOV

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. H.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 955 702 039 268
County of Power
City of Am. Falls
RECEIVED
MAR 8
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
139189

No. _____ St. _____ Registration District No. 25 State File No. _____
Hospital Bethany Primary Registration District No. 2172 Local Registrar's No. 86

FULL NAME OF CHILD _____
(Certificate of no value without full name of child)

Sex of Child <u>boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>Feb 2</u> 192 <u>6</u> (Month) (Day) (Year)
-------------------------	---	-----	---	-----------------------------	---

What bactericidal solution was used in eyes? argyrol
Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER FULL NAME <u>Lloyd R. Reed</u> RESIDENCE <u>Am. Falls</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>40</u> (Years) BIRTHPLACE <u>Nebr.</u> OCCUPATION <u>farmer</u>	MOTHER FULL MAIDEN NAME <u>Madeline Bohn</u> RESIDENCE <u>Am. Falls</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>36</u> (Years) BIRTHPLACE <u>Wis.</u> OCCUPATION <u>housewife</u>
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn 7:20 A M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
(Signature) Dr. H. Schult
By R. J. J
(Physician or midwife)

Give names added from a supplemental report. _____, 192_____

Registrar.
Address _____
Filed 2-5 1926 Genevieve N. D.
Registrar.

2
1918

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. _____
Local Registration No. _____

FULL NAME OF CHILD _____
(Certificate of no value without full name of child)
Sex of Child _____
Date of Birth _____
Month _____
Day _____
Year _____

Number of children of this mother, including present birth _____
Number of children of this mother, including present birth _____

FATHER		MOTHER	
NAME	RESIDENCE	NAME	RESIDENCE
_____	_____	_____	_____
AGE AT LAST BIRTHDAY _____ (Years)	AGE AT LAST BIRTHDAY _____ (Years)	AGE AT LAST BIRTHDAY _____ (Years)	AGE AT LAST BIRTHDAY _____ (Years)
BIRTHPLACE _____	BIRTHPLACE _____	BIRTHPLACE _____	BIRTHPLACE _____
OCCUPATION _____	OCCUPATION _____	OCCUPATION _____	OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
on the above named _____
(Signature) _____
(Physician or midwife)

Give names added from a supplemental report _____
1918
Address _____
Physician _____
Registrar _____

THIS FORM SHALL BE FILED IN THE BUREAU OF VITAL STATISTICS, DEPARTMENT OF PUBLIC WELFARE, BOISE, IDAHO, AND IN THE COUNTY CLERK'S OFFICE, IN THE COUNTY WHERE BORN. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS FORM IS FILED IN THE BUREAU OF VITAL STATISTICS, DEPARTMENT OF PUBLIC WELFARE, BOISE, IDAHO, AND IN THE COUNTY CLERK'S OFFICE, IN THE COUNTY WHERE BORN.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Power

City of American Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

RECEIVED

Registration District No. 25

Primary Registration District No. 2072

St. Anthony Deaconess Hospital

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 52550

Local Registrar's No. 217

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE & SINGLE, MARRIED, WIDOWED OR DIVORCED

White

Single
(Write the word)

5. DATE OF BIRTH

Feb 2nd 1925
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Power Co

10. NAME OF FATHER

F.R. Reed

11. BIRTHPLACE OF FATHER

(State or Country) Neb

12. MAIDEN NAME OF MOTHER

Madeline Boim

13. BIRTHPLACE OF MOTHER

(State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F.R. Reed

(Address) American Falls, Idaho

15.

Filed 2-2 1926 Genevieve Holt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 2nd 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillborn 19
that I last saw alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) hrs. mos. ds.

Contributory
(Secondary)

(Duration) hrs. mos. ds.

(Signed) C. F. Smith

M. D.

2/2/26 (Address) American Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death hrs. mos. days. State hrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

American Falls, Ida

DATE OF BURIAL

2/2/ 1926

20. UNDERTAKER

Andrew Davis American Falls, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the infectious disease, such as tetanus, may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
962-201-001-296
County of Ada
City of Boise

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
APR 5 BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S
139309

No. _____ St. _____ Registration District No. 2 State File No. _____
Hospital St. Alphonsus Primary Registration District No. 1004 Local Registrar's No. 91
FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? 1 and { Number in order of birth 11 Legitimate? yes Date of birth 3 1 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 11 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME Gerry Ross
RESIDENCE 1010 N 12th
COLOR white AGE AT LAST BIRTHDAY 47
(Years)
BIRTHPLACE Mo.
OCCUPATION Carpenter

MOTHER
FULL MAIDEN NAME Lula Brown
RESIDENCE 1610 N 12th
COLOR white AGE AT LAST BIRTHDAY 43
(Years)
BIRTHPLACE Colo.
OCCUPATION N.R.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born live { Stillborn ✓ at 3-1-26-9 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 192____

(Signature) Dr. J. C. Hill
(Physician or midwife)

Address _____
Filed 3-16 1926 R. W. Pratt
Registrar. Registrar.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
APR 5

DO NOT WRITE IN THIS SPACE
State File No. **52607**

PLACE OF DEATH **Bureau of Vital Statistics**
County of **Ada** Registration District No. **2**
City of **Bonne** Primary Registration District No. **1004**
(No. **St. Alphonsus Hosp.**)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Baby Ross**
(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS				
3 SEX Female	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced (write the word) Single		
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stillborn				
6 DATE OF BIRTH (month, day and year)				
7 AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____				
9 BIRTHPLACE (city or town) Bonne Ida (State or country)				
PARENTS	10 NAME OF FATHER Jerry Ross			
	11 BIRTHPLACE OF FATHER (city or town) Mo. (State or country)			
	12 MAIDEN NAME OF MOTHER Lula Brown			
	13 BIRTHPLACE OF MOTHER (city or town) Cal. (State or country)			
14 Informant Jerry Ross (Address) 1610 N. 12, Bonne Ida				
15 Filed 3-16-20 Chas. G. Gage Registrar Taylor Schube & Davis				

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH Mar. 1 19 20 (Month) (Day) (Year)	
17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: Stillborn (duration) _____ yrs. _____ mos. _____ ds.	
CONTRIBUTORY (Secondary) (duration) _____ yrs. _____ mos. _____ ds.	
18 Where was disease contracted If not at place of death? Did an operation precede death? _____ Date of _____ Was there an autopsy? _____ What test confirmed diagnosis? (Signed) J. Gage , M. D. 3/3 (Address) Bonne	
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
19 Place of Burial, Cremation, or Removal Morris Hill Cemetery	Date of Burial 3/3 1920
20. Undertaker Taylor Schube & Davis	Address Bonne Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

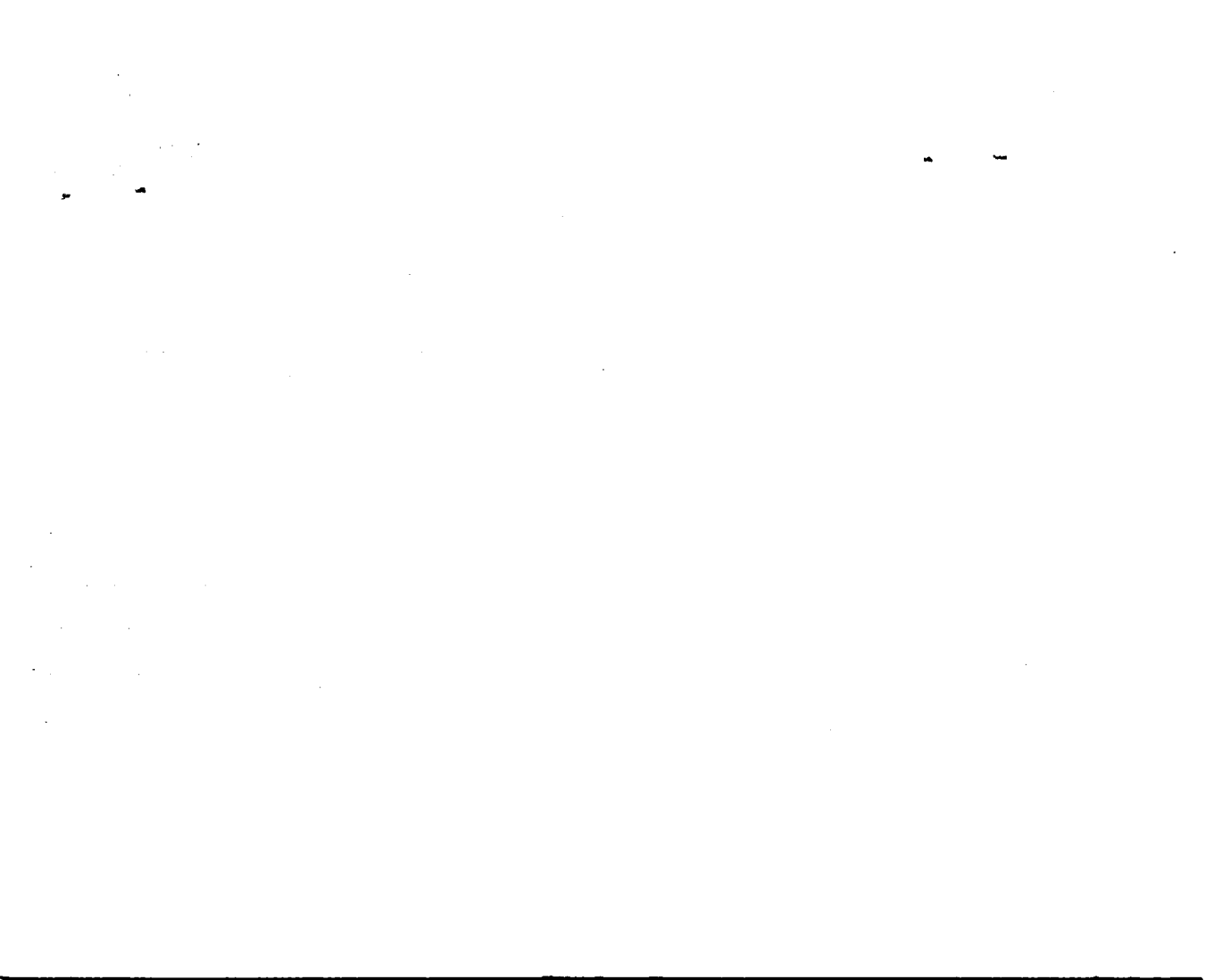
Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH		RECEIVED		STATE OF IDAHO		S
133 102 001-493		APR 5		DEPARTMENT OF PUBLIC WELFARE		
County of <u>Ida</u>		BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS		139324
City of <u>Boise</u>		CERTIFICATE OF BIRTH				
No.	St.	Registration District No.	2	State File No.		
Hospital <u>St. Lukes</u>	Primary Registration District No. <u>1004</u>		Local Registrar's No. <u>77</u>			
FULL NAME OF CHILD <u>James Mitchell Allen</u>						
(Certificate of no value without full name of child)						
Sex of Child	<u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>3-2-1926</u>	
				(To be answered only in event of plural births)	(Month) (Day) (Year)	
What bactericidal solution was used in eyes? <u>1% Silver Nitrate Sol.</u>						
Number of child of this mother, including present birth <u>1</u> Number of child of this mother now living, including present birth <u>0</u>						
FATHER			MOTHER			
FULL NAME	<u>Robert C. Allen</u>		FULL MAIDEN NAME	<u>Vera Mitchell</u>		
RESIDENCE	<u>613 N. 13th St. Boise, Ida</u>		RESIDENCE	<u>613 N. 13th St. Boise</u>		
COLOR	<u>White</u>		COLOR	<u>White</u>		
BIRTHPLACE	<u>Boise Idaho</u>		BIRTHPLACE	<u>New Hampshire</u>		
OCCUPATION	<u>R. R. Baggage man</u>		OCCUPATION	<u>Housewife</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.						
I hereby certify that I attended the birth of this child, who was { <u>Born alive</u> / <u>Stillborn</u> } at <u>10:40 P. M.</u> on the date above stated.						
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }						
Give names added from a supplemental report., 192						
Registrar. <u>3-15-1926</u> <u>P. V. Pratt</u> Registrar.						



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 52608

PLACE OF DEATH
County of Ada
City of Boise
Primary Registration District No. 1001
Local Registrar's No. 68
(If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME Baby Allen James Mitchell Allen
(a) Residence. No. St. Luke's Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS
3 SEX Male
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of
6 DATE OF BIRTH (month, day and year) Stillborn
7 AGE Years Months Days 1 day 1 min.
8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) Boise Ida (State or country)
10 NAME OF FATHER Robert C Allen
11 BIRTHPLACE OF FATHER (city or town) Idaho (State or country)
12 MAIDEN NAME OF MOTHER Vera Mitchell
13 BIRTHPLACE OF MOTHER (city or town) New Hampshire (State or country)
14 Informant Robert C Allen (Address) 613, St. 13th St. Boise Idaho
15 Filed 3-16 1926 R. F. Pratt Registrar

MEDICAL CERTIFICATE OF DEATH 1896
16 DATE OF DEATH Mar 2 1926 (Month) (Day) (Year)
17 I HEREBY CERTIFY, That I attended deceased from Mar 2 1926, to Mar 2 1926, that I last saw him alive on Mar 2 1926, and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Difficult Labor (Complication of Head) Heart beat for a few minutes but no respiration action (duration) yrs. mos. ds. 30
CONTRIBUTORY CONTRAILED FEVER (Secondary) (duration) 31 yrs. mos. ds.
18 Where was disease contracted Boise Idaho If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None (Signed) J. F. Braxton M. D. Mar 3 1926 (Address) Boise Idaho
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
19 Place of Burial, Cremation or Removal Morris Hill Cemetery 3/3 1926
20 Undertaker Schreiber & Davis Address Boise

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH 253-220 011 493		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS	
County of <u>Ada</u>		RECEIVED APR 5 1926 BUREAU OF VITAL STATISTICS	
City of <u>Boise</u>		CERTIFICATE OF BIRTH	
No.	St.	Registration District No. <u>2</u>	State File No. 139338
Hospital		Primary Registration District No. <u>1004</u>	Local Registrar's No. <u>64</u>
FULL NAME OF CHILD <u>Shilshank (no name given)</u> (Certificate of no value without full name of child)			
Sex of Child <u>F.</u>	Twin Triplet or other? <u>—</u> and { Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of birth <u>2-20-1926</u> (Month) (Day) (Year)
What bactericidal solution was used in eyes? <u>no</u>			
Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>0</u>	
FATHER		MOTHER	
FULL NAME <u>Jess W. Kelney</u>		FULL MAIDEN NAME <u>Lula Mitchell</u>	
RESIDENCE <u>Boise Idaho</u>		RESIDENCE <u>Boise Idaho</u>	
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Washington</u>		BIRTHPLACE <u>Washington</u>	
OCCUPATION <u>Landryman</u>		OCCUPATION <u>Spec.</u>	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE			
I hereby certify that I attended the birth of this child, who was { Stillborn / at <u>5:30 a. M.</u> on the date above stated.			
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.		(Signature) <u>M. Chelleyway Japlin</u> <u>Physician</u> (Physician or midwife)	
Give names added from a supplemental report.		Address <u>Boise Idaho</u>	
, 192		Filed <u>3-15-26</u> 192 <u>P. V. Pratt</u>	
Registrar.		Registrar.	

MADE LEGALLY WITH HEADQUARTERS IN NEW YORK CITY
 ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
 DATE 11-19-2001 BY 60322 UCBAW/BJS

CERTIFICATE OF BIRTH

1893388

No. _____
 Registration District _____
 State File No. _____
 Primary Registration District No. _____
 Local Registrar's No. _____
 SEX OF CHILD _____
 DATE OF BIRTH _____
 PLACE OF BIRTH _____
 OCCUPATION _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 RESIDENCE _____
 MOTHER'S NAME _____
 FATHER'S NAME _____
 FULL NAME _____
 Maiden Name _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at _____
 on the date above stated.
 *When born was the attending physician or midwife, then the latter, registered or otherwise, made this return. If not, it is one that neither parent nor anyone other evidence of the birth.
 (Give names added from a supplemental report.)
 (Physician or midwife)
 (Signature)
 Address _____
 City _____
 State _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS			DO NOT WRITE IN THIS SPACE 52287 State File No. _____ Local Registrar's No. <u>60</u>	
RECEIVED PLACE OF DEATH <u>Idaho</u> CERTIFICATE OF DEATH County of <u>Ada</u> City of <u>Boise</u> Registration District No. <u>2</u> Primary Registration District No. <u>1104</u> No. <u>St. Lukes Hospital</u> (If death occurred in a hospital or institution, give its name instead of street and number.)				
2. FULL NAME (a) Residence. No. <u>419 So 11th</u> St. (Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)				
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH <u>1926</u>	
3 SEX <u>F.</u>	4 COLOR OR RACE <u>W.</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>	16 DATE OF DEATH <u>Feb.</u> <u>20</u> <u>1926</u> (Month) (Day) (Year)	
5a If married, widowed, or divorced HUSBAND of (or) WIFE of			17 I HEREBY CERTIFY, That I attended deceased from <u>Feb. 20</u> , 19 <u>26</u> , to <u>Feb. 20</u> , 19 <u>26</u> , that I last saw her alive on <u>Jan. dead</u> , 19 <u>26</u> , and that death occurred, on the date stated above, at <u>about 5A</u> m. The CAUSE OF DEATH* was as follows: <u>Pneumonia and cord during birth</u>	
6 DATE OF BIRTH (month, day and year) <u>Feb. 20, 1926</u>				
7 AGE Years <u>Still Born</u> Months <u>0</u> Days <u>0</u> If LESS than 1 day, ____ hrs. or ____ min.			CONTRIBUTORY (Secondary) (duration) ____ yrs. ____ mos. ____ ds.	
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer			18 Where was disease contracted if not at place of death? Did an operation precede death? <u>no</u> Date of _____ Was there an autopsy? <u>no</u> What test confirmed diagnosis? (Signed) <u>M. E. Caraway-Jafflin</u> M. D. <u>2-20</u> , 19 <u>26</u> (Address) <u>Boise Idaho</u>	
9 BIRTHPLACE (city or town) (State or country) <u>Boise, Idaho</u>			*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
10 NAME OF FATHER <u>J. W. Kelsey</u>			19 Place of Burial, Cremation, or Removal <u>Morris Hill Cemetery</u> <u>2-21</u> <u>1926</u>	
11 BIRTHPLACE OF FATHER (city or town) (State or country) <u>Wm.</u>			20. Undertaker <u>Wm Mc Bratney</u> <u>Boise Ida.</u>	
12 MAIDEN NAME OF MOTHER <u>Lula Mitchell</u>				
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <u>Wm.</u>				
14 Informant <u>Pearl Allen</u> (Address) <u>Boise Idaho</u>				
15 Filed <u>2-27</u> , 19 <u>26</u> <u>R. N. Pratt</u> Registrar				

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

S

RECEIVED

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

74 22081 86K

County of Ada

MAR 12

City of Meridian

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 139378

No. R1 St. Registration District No. State File No.Hospital Primary Registration District No. 11 Local Registrar's No. 60FULL NAME OF CHILD Geraldine Rambo

(Certificate of no value without full name of child)

Sex of Child <u>female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>2 20 1926</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? 1% Sol Silver NitrateNumber of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FULL NAME FATHER

Jimmy Byron Rambo

RESIDENCE

Meridian Idaho R 1 D 1

COLOR

white

AGE AT LAST

BIRTHDAY 29 (Years)

BIRTHPLACE

Kansas

OCCUPATION

Farmer

FULL MAIDEN NAME

Barbara E. Young

RESIDENCE

Meridian Idaho R 1

COLOR

white

AGE AT LAST

BIRTHDAY 27 (Years)

BIRTHPLACE

Missouri

OCCUPATION

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 3:40 a. m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H F NealPhysician
(Physician or midwife)

Address

Meridian Idaho

Filed

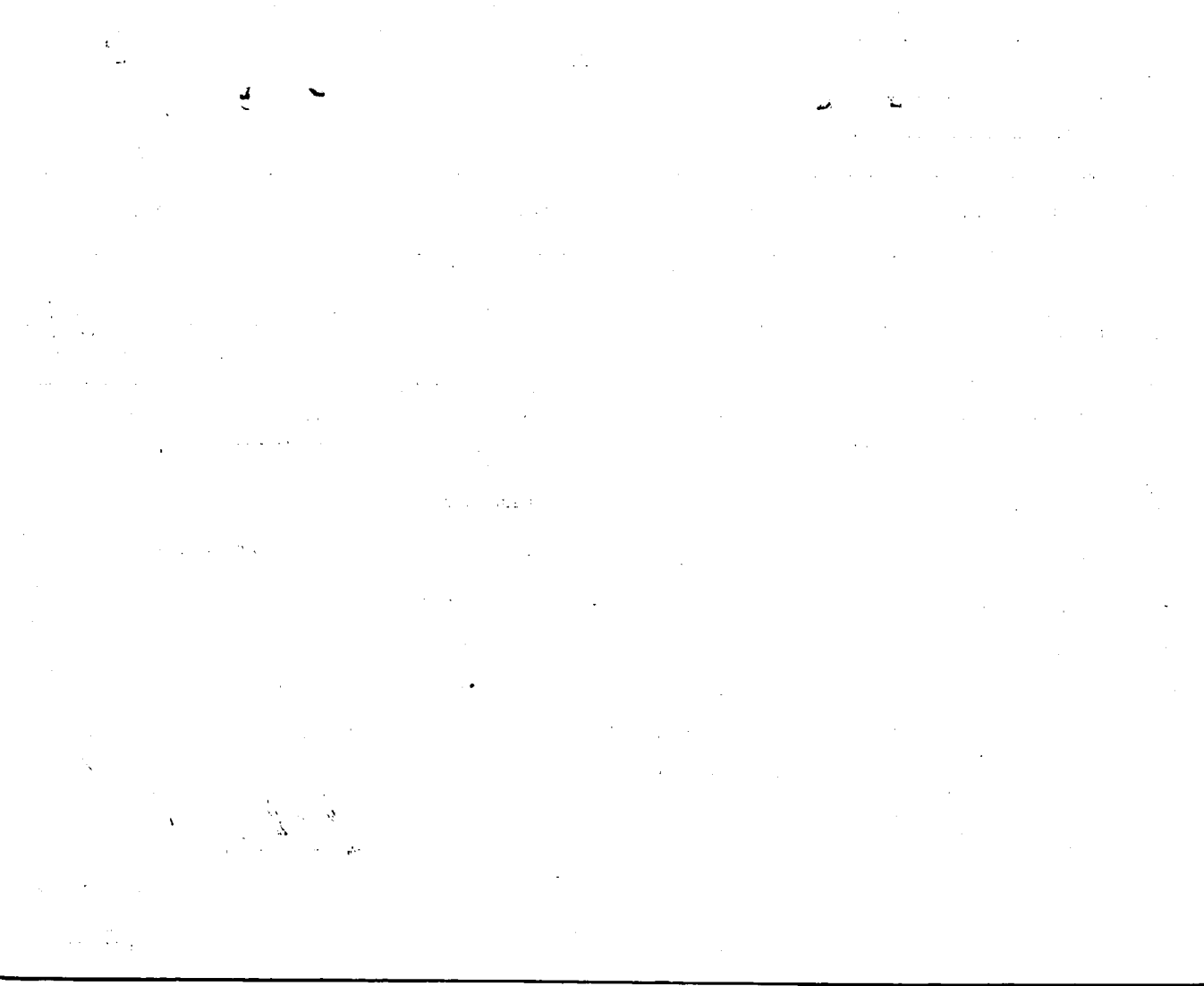
2/3

1926

H F Neal

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH
County of Ada
City of Meridian
If death occurs away from
usual residence, give facts
called for under special in-
formation.

REGISTERED DEATH

Register MAN District No.
P. MAN Registration District No.
(No. STATISTICAL St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 52632
Local Registrar's No. 1
If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME Geraldina Rambo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED S -
(Write the word)

6. DATE OF BIRTH 2 - 20 1926
(Month) (Day) (Year)

7. AGE Born dead. IF LESS than 1
day how many
..... hrs. or
Yrs. Mos. ds. min.?

8. OCCUPATION
(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE
(State or Country) Ada Idaho

10. NAME OF
Father Bryan Rambo

11. BIRTHPLACE
OF FATHER Kan
(State or Country)

12. MAIDEN NAME
OF MOTHER Barbara Young

13. BIRTHPLACE
OF MOTHER Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bryan Rambo
(Address) Meridian RFD #5

15. Filed 2-21 1926 H. H. Neal
Local Registrar

MEDICAL CERTIFICATE OF DEATH 1896

16. DATE OF DEATH 2 - 20 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
2 - 20 1926, to 2 - 20 1926,
that I last saw him alive 1926,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Still birth

(Duration) yrs. mos. ds.

Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) Halbert F. Neal M. D.
2-20 1926 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)
At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence Meridian

19. PLACE OF BURIAL OR REMOVAL Starva Cemetery DATE OF BURIAL 3-1-22 1926

20. UNDERTAKER B. H. Neal ADDRESS Meridian

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED

APR 5

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

BUREAU OF VITAL

STATISTICS

CERTIFICATE OF BIRTH

139401

County of Cassia City of Council No. 655-106-002-312 St. Registration District No. State File No.

Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD Lemmaned

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? no and { Number in order of birth } Legitimate? yes Date of birth 3 6 1926
(Month) (Day) (Year)

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Martin Fuller
RESIDENCE Council Idy
COLOR white AGE AT LAST BIRTHDAY 29
(Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ruby Lakey
RESIDENCE Council Idy
COLOR white AGE AT LAST BIRTHDAY 23
(Years)
BIRTHPLACE Idy
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3 0 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

1926

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made each and the number of each, in order of birth stated.

PLAC

to of

One of

to of

Hospital

FULL NAME

Sex

Child

With Patient

Number of

FULL

NAME

First

Second

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED STATE OF IDAHO
APR 18 DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 52637

PLACE OF DEATH

County of Adams

City of Council

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Wm. J. Fuller

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 3-6-26

7 AGE Years Months Days If LESS than 1 day, 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Council
(State or country)

10 NAME OF FATHER Martin Fuller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Ruby Laker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Idaho

14 Informant Mrs. Ruby Laker
(Address) Council Bluffs

15 Filed Apr 1, 1926 W. J. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 6 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to 19.....
that I last saw h..... alive on 19.....
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born

..... (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted ✓
If not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) D. P. H. 990, M. D.
3-6, 1926 (Address) Council Bluffs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial
19

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		RECEIVED		STATE OF IDAHO		S
203 903-642		MAR 18		DEPARTMENT OF PUBLIC WELFARE		
County of <u>Bonneville</u>		BUREAU OF VITAL STATISTICS		BUREAU OF VITAL STATISTICS		CERTIFICATE OF BIRTH 139417
City of <u>Pocatello</u>	No. <u>413 So. 4th</u>	St.	Registration District No. <u>38</u>	State File No.		
Hospital	Primary Registration District No. <u>2161</u>		Local Registrar's No. <u>2478</u>			
FULL NAME OF CHILD <u>No name Still born</u> (Certificate of no value without full name of child)						
Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u>	and {	Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 3</u>	<u>1926</u>
					(Month)	(Day) (Year)
What bactericidal solution was used in eyes? <u> </u>						
Number of child of this mother, including present birth <u>1</u> Number of child of this mother now living, including present birth <u>0</u>						
FATHER			MOTHER			
FULL NAME <u>Takiji Okiyama</u>			FULL MAIDEN NAME <u>Joyono Fukumoto</u>			
RESIDENCE <u>125 M. Gardens Ave</u>			RESIDENCE <u>miles N. of Pocatello</u>			
COLOR <u>Japanese</u>			COLOR <u>Japanese</u>			
AGE AT LAST BIRTHDAY <u>26</u> (Years)			AGE AT LAST BIRTHDAY <u>26</u> (Years)			
BIRTHPLACE <u>Japan</u>			BIRTHPLACE <u>Japan</u>			
OCCUPATION <u>Gardening</u>			OCCUPATION <u>Housewife</u>			
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE						
I hereby certify that I attended the birth of this child, who was { Born alive } <u>still born</u> { Stillborn } at <u> </u> M.						
on the date above stated.						
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }						
Give names added from a supplemental report. <u> </u> , 192 <u>6</u>						
Address <u>413 So 4th Ave</u>						
Filed <u>3/1</u> 192 <u>6</u>						
Registral. <u> </u> Registrar <u> </u>						

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
FEB 15 1926
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock

Primary Registration District No. 2161

City of Pocatello(No. 574 Yardens St.)File No. 52325Registered No. 4744

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

2 -31926

(Month)

(Day)

(Year)

7. AGE

Still bornIF LESS than 1 day
how many hrs. or
..... mins.?

yrs. mos. ds.

8. OCCUPATION

Trade, profession or
occupation of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello R.T.N.10. NAME OF
FATHERTakiyama11. BIRTHPLACE
OF FATHER

(State or Country)

Japan12. MAIDEN NAME
OF MOTHERYayono Fukumoto13. BIRTHPLACE
OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

TakiyamaPocatello

15.

Filed

2 - 41926

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Still bornBasin Feb31926

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to

191...

that I last saw him alive on

191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)mother

(Duration)

yrs.

mos.

ds.

(Signed)

Mrs. Ann W. Bird74 1926 (Address) 468 So. Main

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello2 - 4 1926

20. UNDERTAKER

ADDRESS

TakiyamaPocatello

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

29 127004-219
PLACE OF BIRTH

RECEIVED
MAR 22

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Beauregard
City of Montpelier
No. _____ St. _____ Registration District No. 52 State File No. 139508

Hospital _____ Primary Registration District No. 2136 Local Registrar's No. _____

FULL NAME OF CHILD Barnard
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? yes Date of birth 1-27 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth		Number of child of this mother now living, including present birth	
FULL NAME	FATHER <u>Ivan P. Barnard</u>	FULL MAIDEN NAME	MOTHER <u>Hazel Pais</u>
RESIDENCE	<u>Montpelier</u>	RESIDENCE	<u>Montpelier</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>32</u> (Years)	AGE AT LAST BIRTHDAY	<u>32</u> (Years)
BIRTHPLACE	<u>Ida</u>	BIRTHPLACE	<u>Ida</u>
OCCUPATION	<u>Ry Engineer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9.30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1926

(Signature) J. P. Gieschen
(Physician or midwife)

Address Montpelier Ida

Filed 2/15/26 1926 W. H. King

Registrar.

Registrar.

Registration

Filed

1913

Registration

Give names and dates of all previous reports.
When there was no attending physician or midwife, then the nearest householder, or midwife, should be named. A physician, etc., should be named when the child is not yet one year old, or the first birth.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the date above stated.

OCCUPATION

BIRTHPLACE

COLOR

AGE AT LAST BIRTHDAY

RESIDENCE

RESIDENCE

BIRTHPLACE

COLOR

AGE AT LAST BIRTHDAY

FATHER

NAME

Number of child of this mother, including present birth.

MOTHER

Number of child of this mother, including present birth.

CERTIFICATE OF CHILD

Hospital

Registration District No.

State File No.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 52667
Registered No.

1. PLACE OF DEATH
County of Bear Lake District No. 52
City of Montpelier District No. 2136
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barnard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
6. DATE OF BIRTH 1 27 1926
(Month) (Day) (Year)
7. AGE Stillborn IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. 3/157 26
Filed 19 26

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 27 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 1-27 19 26
to that I last saw him alive on 19 26

and that death occurred on the date stated above, at 11 M.
The CAUSE OF DEATH* was as follows:

Stillborn
(Duration) (Unknown cause) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. P. Galpin M. D.(Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Montpelier Ida 1/28 26

20. UNDERTAKER

ADDRESS

J. M. Williams Montpelier

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

235 102-004-964

PLACE OF BIRTH

RECEIVED

MAR 22

STATE OF IDAHO

Form V. 6-22-10

BUREAU OF VITAL STATISTICS

S

County of Blaine

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

City of MontpelierRegistration District No. 57File No. 139512

No. _____ St. _____

Primary Registration District No. 2136

Registered No. _____

Hospital _____

FULL NAME OF CHILD _____

Sex of Child <u>Boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth <u>1</u>	Legiti- mate? <u>yes</u>	Date of Birth <u>2-2</u> <u>26</u> (Month) (Day) (Year)
FULL NAME <u>L. C. Stephens</u>	FATHER		FULL MAIDEN NAME <u>Stella Rodenick</u>	MOTHER
RESIDENCE <u>Montpelier</u>			RESIDENCE <u>Montpelier</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)		COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>17</u> (Years)
BIRTHPLACE <u>Bennington</u>			BIRTHPLACE <u>Orbin, Ia</u>	
OCCUPATION <u>Labr</u>			OCCUPATION <u>Imp</u>	

Number of child of this mother, including present birth. 1Number of children of this mother now living, including present birth. 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stella Rodenick at 130 M. on the date above stated.

(born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. V. C. Wiley
Physician
(Physician or midwife)

Given names added from a supplemental report

Address

Filed

Montpelier, Idaho
3/15 1926

Registrar

2

SECRET

ENGINE ROOM
SECRET ROOM
SECRET ROOM

END

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

139575

CERTIFICATE OF BIRTH

S

County of Bonneville City of Idaho Falls
 No. 83-111010-795 St. Registration District No. 73 State File No. S
 Hospital Spencer Primary Registration District No. 210 Local Registrar's No. 13
 FULL NAME OF CHILD JAMES WESLEY HOLDEN

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? no and { number in order of birth } Legitimate? yes Date of birth Feb 11 1926
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 0Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
 FULL NAME James Wesley Holden
 RESIDENCE Idaho Falls Idaho
 COLOR White AGE AT LAST BIRTHDAY 46 (Years)
 BIRTHPLACE Nebraska
 OCCUPATION Surgeon

MOTHER
 FULL MAIDEN NAME Suey Irene Pierce
 RESIDENCE Idaho Falls Idaho
 COLOR White AGE AT LAST BIRTHDAY 32 (Years)
 BIRTHPLACE Sorengo Idaho
 OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 4:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

192

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

192

Address _____

Printed _____

Signature _____

I hereby certify that I attended the birth of this child, who was born at _____ on the date above stated.

(Physician or midwife)

(Signature)

When there was no attending physician or midwife, then the father, householder, etc. should make this return. A neighbor who is one that neither physician nor other evidence of the child.

These names added from a supplemental report.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

OCCUPATION _____

BIRTHPLACE _____

Color _____

AGE AT LAST BIRTHDAY _____

RESIDENCE _____

FULL MAIDEN NAME _____

Number of child of this mother, including present birth _____

FATHER

Number of child of this mother, including present birth _____

FULL NAME _____

OCCUPATION _____

BIRTHPLACE _____

Color _____

AGE AT LAST BIRTHDAY _____

RESIDENCE _____

FULL NAME _____

Number of child of this mother, including present birth _____

MOTHER

Number of child of this mother, including present birth _____

DATE OF BIRTH (Month) (Day) _____

TIME OF BIRTH _____

PLACE OF BIRTH _____

SEX _____

WEIGHT _____

LENGTH _____

HEAD _____

ARM _____

LEG _____

FEET _____

HAIR _____

EYES _____

SKIN _____

TEETH _____

Other _____

Signature _____

Printed _____

Address _____

192

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 52724
Registered No. 34-

1. PLACE OF DEATH
County of Boonville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Infant Holden

RECEIVED
MAR 21 1926
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED single
(Write the word.)
6. DATE OF BIRTH Feb 11 1926
(Month) (Day) (Year)
7. AGE Boon. dead. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER J. Wesley Holden

11. BIRTHPLACE OF FATHER Neb.
(State or Country)

12. MAIDEN NAME OF MOTHER Lucy Puer.

13. BIRTHPLACE OF MOTHER Ida
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur W. Holden
(Address) Idaho Falls, Idaho

15. Filed Feb 12 1926
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 11 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.
Contributory (Secondary) Clampers in Mother
(Duration) yrs. mos. ds. 36 hrs.
(Signed) W. C. Cullen M. D.
19 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL Feb 13 1926
20. UNDERTAKER C. C. Hayes ADDRESS City

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name or *gin*; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

559130000 766

County of

Bonneville
Idaho Falls

City of

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

RECEIVED
MAR 24

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

139577

No. _____ St. Registration District No. 23 State File No. _____

Hospital Spencer Primary Registration District No. 212 Local Registrar's No. 17

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child	Male	Twin Triplet or other?	} and {	Number in order of birth	Legiti- mate?	Yes	Date of birth	Jan. 30	1926
							(Month)	(Day)	(Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth. 2 Number of child of this mother now living, including present birth. 0

FULL NAME	FATHER
RESIDENCE	Idaho Falls Idaho
COLOR	White
BIRTHPLACE	Pocatello Idaho
OCCUPATION	Laborer

FULL MAIDEN NAME	MOTHER
RESIDENCE	Idaho Falls
COLOR	white
BIRTHPLACE	Ucon Idaho
OCCUPATION	Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ☒ Stillborn ☐ ☒ Live at 11 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

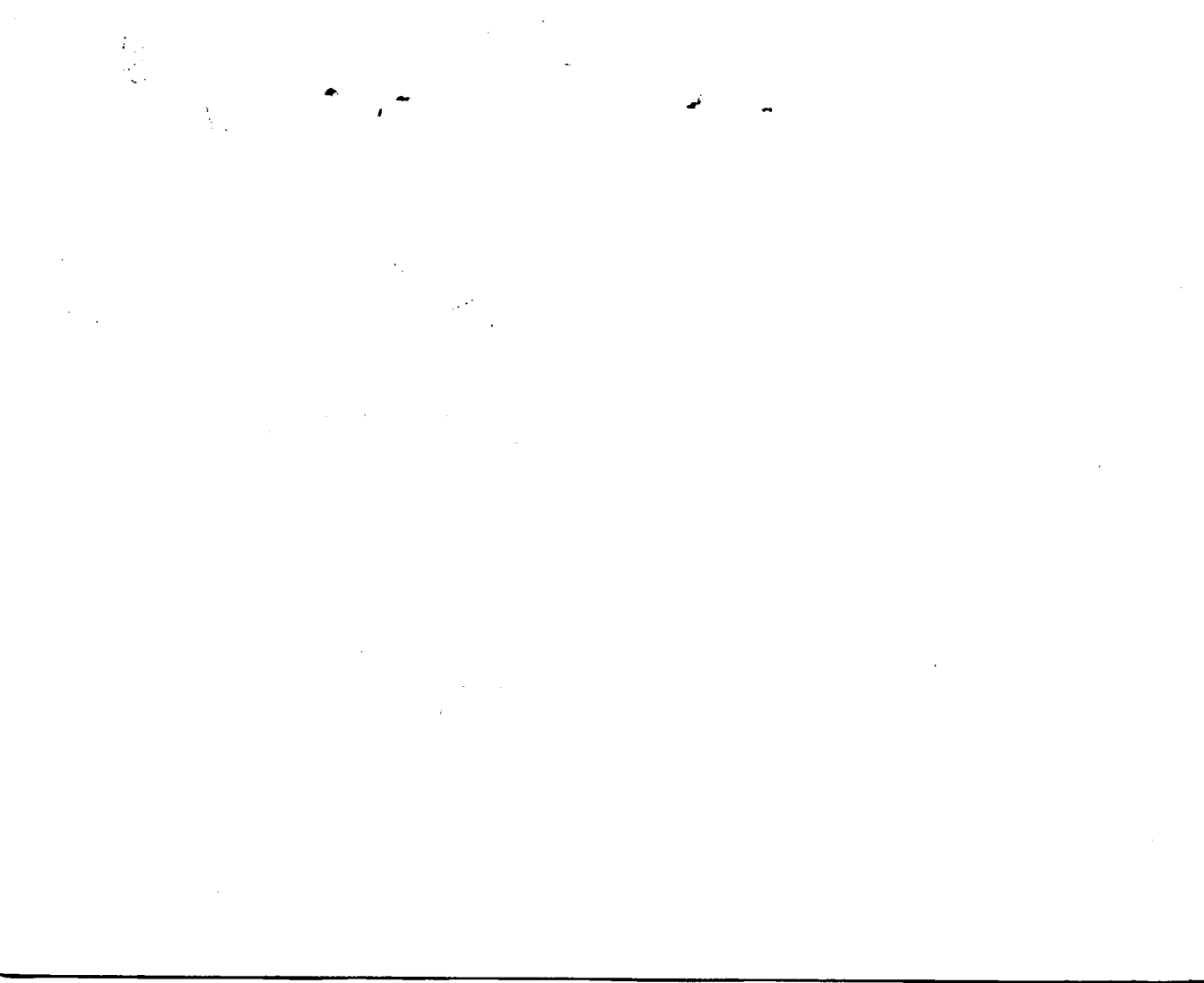
Filed

21 3

1926

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bonneville*
City of *Idaho Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATHRegistration District No. *73*
Primary Registration District No. *214-0*
(No. *Spencer St.* St.)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. *52735*Local Registrar's No. *24*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Single*
(Write the word)

6. DATE OF BIRTH

Jan 30 1926
(Month) (Day) (Year)

7. AGE

Born Dead
IF LESS than 1 day how many
Yrs. Mos. ds. hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)
261

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Harper Nelson

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Laura Goodson

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harper Nelson*

(Address)

15. Filed *2/1*19 *26* *Amundson*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 30 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at *N.*

The CAUSE OF DEATH* was as follows:

Still Birth, due to contracted filaria and instrumental delivery & pressure on cord.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

1926 (Address) *Idaho Falls, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida.

DATE OF BURIAL

2/1 1926

20. UNDERTAKER

Idaho Falls, Ida.

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

815-125 009 493

County of Bonner

City of Priest River

No. 1 St. No. 1

Hospital

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED
APR 8

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH 1396/108

Primary Registration District No. 2185 Local Registrar's No. 472

FULL NAME OF CHILD Joseph Hansmaier

(Certificate of no value without full name of child)

Sex of Child	<u>Male</u>	Twin Triplet or other?	<u> </u>	and {	Number in order of birth	Legitimate?	<u>Yes</u>	Date of birth	<u>March 25 1926</u>
									(Month) (Day) (Year)

What bactericidal solution was used in eyes? Slack's solution Dead

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Henry Hansmaier
RESIDENCE Priest River
COLOR white AGE AT LAST BIRTHDAY 50 (Years)
BIRTHPLACE Germany
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Gertrude Mittag
RESIDENCE Priest River, Idaho
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Germany
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 1:00 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. , 1926

(Signature) E. E. Settleff M.D.
(Physician or midwife)

Address Priest River, Idaho

Filed April 1 1926 E. E. Settleff Registrar.

When there was no attention paid to the last part of the sentence, the word "and" was not used, and the sentence was not complete.

MARGIN RESERVED FOR PARTIAL RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 52703

Local Registrar's No. 169

PLACE OF DEATH

Bonner

RECEIVED CERTIFICATE OF DEATH

County of **Bonner**

Registration District No. **85**

City of **Priest River**

Registration District No. **2185**

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME **Joseph Hansmeier**

(a) Residence. No. _____

St. _____

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Mar 25

7 AGE

Years

Months

Days

If LESS than
1 day 0 hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **no**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) **Priest River**
(State or country)

10 NAME OF FATHER

Henry Hansmeier

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Gertrude Mittag

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant

(Address)

Henry Hansmeier
Priest River

15

Filed **April 1 1926**

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March

25

1926

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

april Mar. 25 26, to _____, 19____.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn.

Cause unknown

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? **no**

What test confirmed diagnosis?

(Signed)

Mar. 25 1926

M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

3/25/1926

20. Undertaker

Address

Henry Hansmeier

Priest River

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

693 205 014 168
 PLACE OF BIRTH
 County of Canyon
 City of Middleton
 No. _____ St. _____

RECEIVED
 APR 12 1926
 STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 BUREAU OF VITAL CERTIFICATE OF BIRTH
 STATISTICS
 Registration District No. 3 File No. 139661

S

Hospital _____ Primary Registration District No. 2005 Registered No. X46

FULL NAME OF CHILD

Baby Williams

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and	Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth <u>April 5</u> 192 <u>6</u>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

What bactericidal solution was used in eyes? Still born

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 3

FULL NAME <u>Thomas H. Williams</u>	FATHER	FULL MAIDEN NAME <u>Alta Grace Johnson</u>	MOTHER
RESIDENCE <u>Middleton - Idaho</u>		RESIDENCE <u>Middleton - Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>94</u> (Years)
BIRTHPLACE <u>Osark, Missouri</u>		BIRTHPLACE <u>Halesburg - Illa</u>	
OCCUPATION <u>Carpenter</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born at 12-10-P M. on the date above stated. (Born alive or still born)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

_____, 19____

 Registrar.

(Signature)

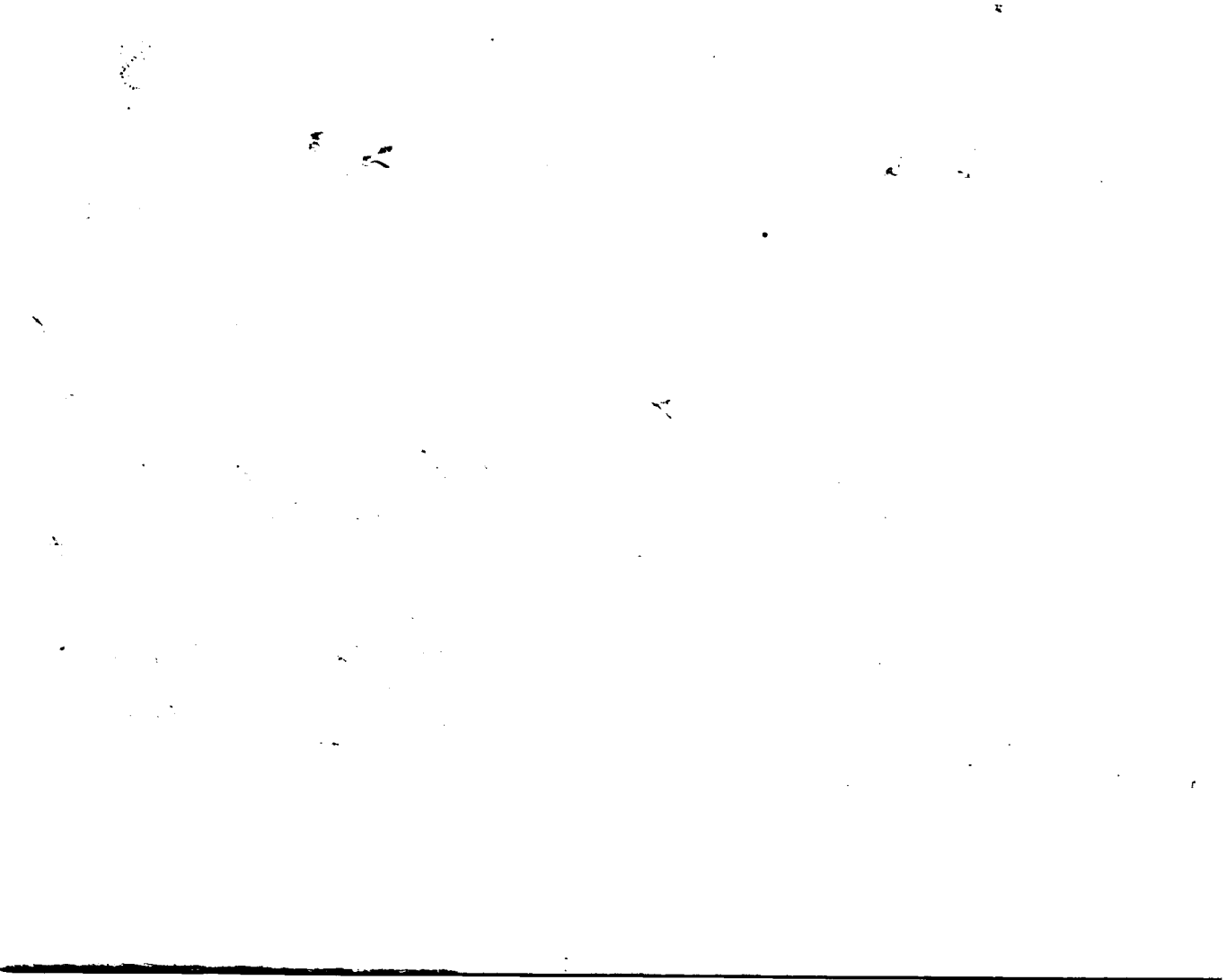
(Physician or midwife)

Address

Filed

4-5-1926

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Canyon

City of Middleton

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

APR 18 1926

Registration District No.

BUREAU OF VITAL STATISTICS

Registration District No. 2005

No.

St.)

2. FULL NAME

Baby Williams

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 52737

Local Registrar's No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

White

Single

(Write the word)

6. DATE OF BIRTH

4-5-26

(Month)

(Day)

(Year)

7. AGE

Stillborn

IF LESS than 1 day how many
..... hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

Thomas H Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Alta Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Williams

(Address)

Middleton Ida

15.

Filed

5-5-

1926

John S. Meyers -
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4-5-

(Month)

(Day)

1926

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 5 - 1926 to April 5 - 1926,
that I last saw ~~dead~~ ^{live} on April 5 - 1926,
and that death occurred on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:

Still born - died before birth -

(Duration) yrs. mos. ds.

Contributory Two weeks past due.
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John S. Meyers, M. D.

19. (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Middleton Cemetery

DATE OF BURIAL

4-5-26 19

20. UNDERTAKER

Paul L. Case

ADDRESS

Caldwell Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

79-223-229-295
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
APR 10
BUREAU OF VITAL STATISTICS

S

139990

County of Latah
City of Museon
No. _____ St. _____
Hospital _____
Registration District No. 61 File No. _____
Primary Registration District No. 1011 Registered No. 20
FULL NAME OF CHILD Still born
(Certificate of no value without full name of child.)

Sex of Child Female Twin Triplet or other? _____ and _____ Number in order of birth _____ Legiti- mate? yes Date of birth Feb 27 1926
(Month) (Day) (Year)
(To be answered only in event of plural births)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth 10

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Geo. A. Pratt</u>	<u>Museon</u>	<u>Sue Breen</u>	<u>Museon</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Laborer</u>		OCCUPATION <u>house wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____ M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Clarke
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address _____
Filed Feb 12 1926 W. H. Carithers
Registrar.

24

25

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of LatahCity of MOSCOW

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 601Primary Registration District No. 1011

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 52891Registered No. 116

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Virvinia Lois Pratt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
Child

(Write the word.)

6. DATE OF BIRTH.

Feb. 23 1 1926
(Month) (Day) (Year)

7. AGE

StillbornIF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Geo. A. Pratt

11. BIRTHPLACE OF FATHER

(State or Country) Minn.

12. MAIDEN NAME OF MOTHER

Susie Lois Breeder

13. BIRTHPLACE OF MOTHER

(State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. A. Pratt(Address) MOSCOW, Idaho.

15.

Filed 2/23 1926

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 23, 1926 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw h..... alive on Still Born 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Clark M. D.(Address) 191 L. 4 Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Stepoe, Wash. 2/23/26 191

20. UNDERTAKER ADDRESS

H.R. SHORT MOSCOW

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.,* of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc.; when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

643/24-03/242
PLACE OF BIRTH

Lewis

County of.....

City of Nezperce RFD

No. 144 St.

Hospital.....

FULL NAME OF CHILD.....

Stillborn

(Certificate of no value without full name of child.)

Sex of Child	male	Twin Triplet or other?	---	and	Number in order of birth	---	Legiti- mate?	Yes	Date of birth	Mar 24	1926
									(Month)	(Day)	(Year)

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FULL NAME John Fuchs FATHER

FULL MAIDEN NAME Louise Magdalene Bubel MOTHER

RESIDENCE Nezperce RFD

RESIDENCE Nezperce RFD

COLOR white AGE AT LAST BIRTHDAY 56 (Years)

COLOR white AGE AT LAST BIRTHDAY 41 (Years)

BIRTHPLACE Germany

BIRTHPLACE S. Dakota

OCCUPATION ancher

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE..... 1.40 A

I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature).....

(Physician or midwife)

Give names added from a supplemental report.

Address.....

Craigmont Idaho

Filed 3-28-1926

Registrar.

Albert Huff
Registrar.

Albert Huff
Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED
MAR 31
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

State File No.....

Primar Registration District No..... Local Registrar's No. 282

139994

S

THIS IS A PRELIMINARY REPORT AND SHOULD NOT BE USED FOR ANY PURPOSES WITHOUT THE SIGNATURE OF THE REGISTRAR.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of _____
City of _____
No. _____
Hospital _____
Date of Birth _____

1933

FULL NAME OF CHILD

Sex of Child _____
Single or Married _____
Twin _____
Triplet _____
or other _____
(To be answered only in case of multiple births)
Number of children born _____
Date of Birth _____
Month _____
Day _____
Year _____

What obstetrical solution was used in case?

Name of Mother _____
Name of Father _____
Name of Mother _____
Name of Father _____
Name of Mother _____
Name of Father _____

Residence _____
Color _____
Age at last birthday _____
Birthplace _____
Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was _____
on the date above stated.

When there was no attending physician or midwife, then the father, mother or other person should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Other matters added from a supplemental report.

Address _____
Signature _____
Date _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS

PLACE OF DEATH
Lewis

County of _____

City of Nezperce RFD Primary Registration District No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)
Stillborn

2. FULL NAME _____

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) ---

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Mar 24, 1926

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Nezperce RFD
(State or country)

10 NAME OF FATHER John Fuchs

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Magdalene Bubel

13 BIRTHPLACE OF MOTHER (city or town) S Dakota
(State or country)

14 Informant John Fuchs, Registrar
(Address) Nezperce Idaho

15 Filed 3-28-26 Albert Huff
Registrar

DO NOT WRITE IN THIS SPACE

State File No. 52933

Local Registrar's No. 113

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 24, 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 24 never, 1926, to Mar 24, 1926, that I last saw him alive on Mar 24, 1926, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Premature birth- 5 and half months developed

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____
If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) R. G. Durrant M. D.

3/24 1926 (Address) Cozquintilla

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Nezperce Catholic Cemetery Date of Burial Mar 24 1926

20. Undertaker Neighbors of Fuchs Address Nezperce Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

299213-038-295
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of *Minidoka*

APR 8

City of *Rupert*

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No.

St. Registration District No.

19 State File No.

140066

Hospital

Primary Registration District No.

2015 Local Registrar's No.

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of Child

Female

Twin
Triplet
or other?

} and {

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

Mar 13 1926
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Neo-Silver 15%

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

1

FATHER
FULL NAME

Joseph Adam Krivance

RESIDENCE

Rupert

COLOR

white

AGE AT LAST
BIRTHDAY

33
(Years)

BIRTHPLACE

Nebr.

OCCUPATION

Farmer

MOTHER
FULL MAIDEN NAME

Blanche Ringford

RESIDENCE

Rupert

COLOR

white

AGE AT LAST
BIRTHDAY

31
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Born alive
Stillborn

7:30 a. m.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

E. E. Elmore

(Physician or midwife)

Address

Rupert

Filed

3-13-1926

E. E. Elmore

Registrar.

Registrar.

RECEIVED OF THE UNITED STATES DEPARTMENT OF THE INTERIOR

DATE OF
DEED
(Month) (Year)

THIS DEED IS VALID IN ALL STATES

ADDED AT LAST

CERTIFICATE OF AWARD OF LAND OR MINES

TO THE
LAND
MINES

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

8662061035-819

PLACE OF BIRTH

RECEIVED

APR 9

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Nez Perce

City of Lewiston

No. _____ St. _____

Registration District No. 96

File No. 140117

Hospital St. Joseph's

Primary Registration District No. 1009

Registered No. _____

FULL NAME OF CHILD

unnamed child Hoffman
(Certificate of no value without full name of child.)

Sex of
Child

Female

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

Mar 6

1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth. 3rd

Number of child of this mother now living, including present birth. 2

FULL
NAME

FATHER

Walter Hoffman

RESIDENCE

Agatha, Idaho

COLOR

White

AGE AT LAST

BIRTHDAY

3.6

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Eliza Harvey

RESIDENCE

Agatha, Idaho

COLOR

White

AGE AT LAST

BIRTHDAY

31

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Stillborn

at

1 a. M.

(Born alive or stillborn)

* When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

E. L. Broadbent

(Physician or midwife)

Give names added from a supplemental report.

Address

Lewiston, Idaho

Filed

Apr 7 1926

Ronan E Bruce

Registrar.

Registrar.

CERTIFICATE OF BIRTH

File No.

Registered No.

Place of Birth

Date of Birth

NOTED

AND

DATE

CERTIFICATE OF ATTENDANCE

Child's Name

Address

Signature

Witness

Signature

Date

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
APR 9 1926
CERTIFICATE OF DEATH
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

52973

State File No.

Local Registrar's No.

PLACE OF DEATH
County of Neper
City of Idaho
Registration District No. 1009
Primary Registration District No. 1009

(No. of death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Hoffman

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Unknown 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Mar 6-1926

7 AGE Years Months Days 21 If LESS than 1 day, hrs. min. St. Born

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston
(State or country)

10 NAME OF FATHER John Hoffman

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Delia Thomson

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant Walter Hoffman
(Address)

15 Filed Apr 8 1926 Irvin E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 5-1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 5-1926, to Mar 5-1926, that I last saw him alive on Dead born, 1926, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature birth induced
Therapeutic abortion. Dead
born (duration) yrs. 6 mos. ds.

CONTRIBUTORY vomiting of pregnancy
(Secondary) of mother (duration) yrs. 1 mos. ds.

18 Where was disease contracted ✓
if not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edw. B. Search, M. D.
Mar 6, 1926 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Lewiston Ida Date of Burial Mar 6 1926

20 Undertaker Passar Undertaking Co Address Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

759-205-078-764
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Payette

City of Payette

RECEIVED

MAR 31 1926

CERTIFICATE OF BIRTH 140141

No. _____ St. _____ Registration District No. 4 State File No. _____

Hospital _____ Primary Registration District No. 1008 Local Registrar's No. 24

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth Feb 3 - 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Silver

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME S E Garber
RESIDENCE Payette Ida -
COLOR White AGE AT LAST BIRTHDAY 42
(Years)
BIRTHPLACE Idaho
OCCUPATION Miner

MOTHER
FULL MAIDEN NAME Dora E Powell
RESIDENCE Payette Ida -
COLOR White AGE AT LAST BIRTHDAY 36
(Years)
BIRTHPLACE Idaho
OCCUPATION Dentist

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive on the date above stated. 7:30 a. m.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. C. Woodward

(Physician or midwife)

Address Payette Ida

Filed Mar 20 1926 J. C. Woodward

Registrar.

Registrar

WHO
AND
THE

MAR 31

THE

Priority Registration District No.

(Certificate of no value without full name of child)

Date of Birth
(Month) (Day)

Sex
(Male) (Female)

and {
The be married only in case of legal birth

was used in case

Number of child of the mother, how lived, including present

MOTHER

FULL
NAME
MOTHER

FATHER

NAME

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

AGE AT LAST
BIRTHDAY

COLOR

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was born on [] at []

(Signature)

(Physician or midwife)

Address

City

When there was no attending physician or midwife present the father, mother, or other person present at the birth should sign this certificate and the child should be registered as a non-registered child.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No.

Registration District No.

(No.)

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 52543

Local Registrar's No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female

White

Infant
(Write the word)

6. DATE OF BIRTH

Feb

5

1926

(Month)

(Day)

(Year)

7. AGE

Stillborn

Yrs.

Mos.

ds.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Payette Idaho

10. NAME OF

Father

S. E. Gerber -

11. BIRTHPLACE

OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME

OF MOTHER

Dora Janet Powell

13. BIRTHPLACE

OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

S. E. Gerber
Payette, Idaho

15.

Filed

Feb 9

1926

J. B. Woodward

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

5

1926

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 5 1926 to Feb 5 1926

that I last saw ~~alive on~~ 19

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

2/5-1926 (Address) J. B. Woodward
Payette, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho

Feb 6 1926

20. UNDERTAKER

ADDRESS

S. E. Gerber

Payette, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

275218-039-393
PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

APR 12

CERTIFICATE OF BIRTH

BUREAU OF VITAL
STATISTICS

140163

County of Power

City of Am. Falls

No. _____

St.

Registration District No. _____

25

State File No. _____

885

Hospital _____

Primary Registration District No. 2072

Local Registrar's No. _____

FULL NAME OF CHILD

Oliver Elaine Spear

(Certificate of no value without full name of child)

Sex of
Child

girl

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

Feb 18

1926

(To be answered only in event of plural births)

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

8

Number of child of this mother now living, including present birth

6

FULL
NAME

FATHER

Chas. D. Spear

RESIDENCE

Am. Falls

COLOR

white

AGE AT LAST
BIRTHDAY

44

(Years)

BIRTHPLACE

Iowa

OCCUPATION

farmer

FULL
MAIDEN
NAME

MOTHER

Armenta Lickenteller

RESIDENCE

Am. Falls

COLOR

white

AGE AT LAST
BIRTHDAY

41

(Years)

BIRTHPLACE

S. Dakota

OCCUPATION

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Boysen at _____ M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

Dr. V. S. Logan

By R. J.

(Physician or midwife)

Address

American Falls

Filed

4-16

1926

Registrar.

Registrar.

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE
NEW YORK 17, N. Y.

[illegible]

Attachment

541

CERTIFICATE OF ATTENDING PHYSICIAN OR SURGEON

I (March) recall that I attended the birth of this child, who was born on 1/1/1941.

Initial work (Feb 1941) on

When there was no attendance provided, an individual then the local authorities should make the person a citizen of the country that neither provides nor shows any evidence of life after death.

Report International a word before - 444444-4444

ИЮЛ'АВГУСТО

NOTES

YALP: 116

NO. 10

TRAJTA 3DA
YAGHTRID

NOTES

34-14410-2

SECRET

DATE
PAGE
NAME

ATOM

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1977 1928 1929 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1940 1941 1942 1943 1944 1945 1946 1947 1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745

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1980

(180 Y)

State Of Idaho
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, APR 16 1926

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

RECEIVED
MAY 4 1926
BUREAU OF VITAL
STATISTICS

of Birth { CITY American Falls FILE NO. 140163
ST. Idaho DATE OF BIRTH Feb 18th 1926
COUNTY Power SEX OF CHILD Female
FATHER Chas. H. Spear MOTHER Anninta Liskingeller
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Olive Elaine Spear

Mr. Chas. H. Spear
Signature of Father or Mother.

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

For Males:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at once with the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

FATHER	MOTHER	SEX OF CHILD	DATE OF BIRTH	FILE NO.	CITY
(Maiden Name)					

of
Birth

I HEREBY CERTIFY that the child herein described has been named:

William W. Davis

Signature of Father or Mother

RECEIVED APR 12 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Power*
City of *Am. Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Spear

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

girl

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Feb. 19

(Month)

(Day)

1926
(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Chas. H. Spear

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Arminta Lickenteller

13. BIRTHPLACE OF MOTHER

(State or Country)

S. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Am. Falls, Idaho

15.

Filed *4-10*

1926

Genevieve North

Local Registrar

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *52996*

Registered No. *979*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 19

(Month)

(Day)

1926
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 19 1926, to *Feb 19* 1926.

that I last saw him alive on *Feb 19* 1926.

and that death occurred on the date stated above, at *11 P. M.*

The CAUSE OF DEATH* was as follows:

*Pneumonia
Tuberculosis*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

V. H. Spear

M. D.

3-21 1926 (Address) *Am. Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

215-2131040-413
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

MAR 24

BUREAU OF CERTIFICATE OF BIRTH
STATE

140172

County of Shoshone

City of Wallace

No. _____ St. Registration District No. 70 State File No. _____

Hospital Providence Primary Registration District No. 1011 Local Registrar's No. 18

FULL NAME OF CHILD Stillborn Infant

(Certificate of no value without full name of child)

Sex of Child <u>F</u>	Twin Triplet or other? <u>1</u> } and { Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>1-13</u> 192 <u>6</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? _____

FATHER		MOTHER	
FULL NAME	<u>Edward Savage</u>	FULL MAIDEN NAME	<u>Lempy Mackey</u>
RESIDENCE	<u>Mullan, Ida</u>	RESIDENCE	<u>Mullan, Ida</u>
COLOR	<u>W</u>	COLOR	<u>W</u>
AGE AT LAST BIRTHDAY	<u>24</u> (Years)	AGE AT LAST BIRTHDAY	<u>21</u> (Years)
BIRTHPLACE	<u>Delta, Idaho.</u>	BIRTHPLACE	<u>Finley, Id</u>
OCCUPATION	<u>Miner</u>	OCCUPATION	<u>House</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 8:45 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1926
Registrar.

(Signature) [Signature]

(Physician or midwife)

Address [Address]

Filed Jan 21 1926 [Signature]

NOTED: This is a duplicate of the original report. The original report is being retained in the file. The duplicate is being placed in the file for your information. The original report is being retained in the file. The duplicate is being placed in the file for your information.

1. The patient was a female, aged 25 years, who was admitted to the hospital on 10/10/44. She was brought to the hospital by her mother. She was found unconscious on the street. She was taken to the hospital by a police officer. She was brought to the hospital by her mother. She was found unconscious on the street. She was taken to the hospital by a police officer.

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CERTIFICATE OF BIRTH

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FORM V. S. No. 5-25 M-1-19.

1. PLACE OF DEATH

County of Shoshone
City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

CERTIFICATE OF DEATH

Registration District No. 70Primary Registration District No. 192(No. Providence Hospital)STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICSState File No. 53001Local Registrar's No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale white

(Write the word)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
..... hr. or
..... m n.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
Father11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1926

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

17. I HEREBY CERTIFY, That I attended deceased

19..... to

that I last saw her alive onand that death occurred on the date stated above, at 83

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida1-15-1926

20. UNDERTAKER

ADDRESS

Bruce A. MottelWallace Ida

**MARSHEN RUMOR—THE
ALIVE, WHEN UNPUBLISHED.
NOTES SHOULD BE CREDITED TO**

VIND FOR

1

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcema, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

469-289-040-867
PLACE OF BIRTH

RECEIVED
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone

City of Wallace

MAR 24
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

140173

No. 1 St. 70 Registration District No. 70 State File No. 1

Hospital Wallace Primary Registration District No. 1011 Local Registrar's No. 9

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of Child female Twin Triplet or other? } and { Number in order of birth 1 Legitimate? Yes Date of birth Jan 9 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME William Dorvity
RESIDENCE Idaho
COLOR white AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Ireland
OCCUPATION Mill Hand

MOTHER
FULL MAIDEN NAME Rose Higgins
RESIDENCE Idaho
COLOR white AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Ireland
OCCUPATION H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn born alive M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

W. C. Berlich M. D.

(Physician or midwife)

Address

Wallace Idaho

Filed

Jan 31 1926

G. L. Hughes

Registrar.

Registrar.

Birth (Month) (Day)

Form of 1911 and 1912 collection data

United States of America (U.S. National Archives)

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

1.11.17
142014A
2014

附錄

REFERENCE

2010

YASUKIYAMA

22-1111

Keywords: child sexual abuse; disclosure; social support

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

RECEIVED

TO THE HONORABLE SECRETARY OF THE ARMY
WASHINGTON, D. C.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 53000

PLACE OF DEATH

County of Shoshone Registration District No. 70

City of Wallace Primary Registration District No. 1014

Local Registrar's No. 2

(If death occurred in a hospital or institution give its name instead of street and number.)
BUREAU No. Wallace Hospital

2. FULL NAME Baby Dorothy (Stillborn)

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 9 - 1926

7 AGE Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wallace Idaho
(State or country)

10 NAME OF FATHER Mrs Dorothy

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Rosann Higgins

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Dorothy
(Address) (Frisco) Lark 2da

15 Filled Jan 13, 1926 W. L. Lingley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 9 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1926, to Jan 9, 1926
that last saw him alive on _____, 19____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) Nephritis toxemia

(duration) _____ yrs. 1 mos. _____ ds.

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Physic. Examination
(Signed) T. R. Lingley, M. D.

Jan 11, 1926 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Wallace Idaho Date of Burial Jan 13, 1926

20. Undertaker Ward and Co Address Wallace Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

459-225,042-273
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls

APR 12

City of Twin Falls

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

140231

No. _____ St. _____ Registration District No. 37 State File No. _____

Hospital T. G. County Primary Registration District No. 2085 Local Registrar's No. _____

FULL NAME OF CHILD Margaret Lois Meredith
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>March 25, 1926</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME James Arthur Meredith
RESIDENCE Roseworth Idaho
COLOR White AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Marne Iowa
OCCUPATION Ranchman

MOTHER
FULL MAIDEN NAME Salome Mildred Patton
RESIDENCE Roseworth Idaho
COLOR White AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Bevier Missouri
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:45 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 192____

(Signature) D. G. Jennings
(Physician or midwife)

Address Bull, Ida.

Filed Apr 12 1926 John H. Houghlin
Registrar.

Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **54063**

PLACE OF DEATH

County of Twin Falls

Registration District No. 37

City of _____

Primary Registration District No. 2015

Local Registrar's No. _____

(No. Twin Falls County Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Margaret Lois Meredith

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word)
Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 25, 1926

7 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.
00 00 00

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Twin Falls Idaho
(State or country)

10 NAME OF FATHER

James Arthur Meredith

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Iowa

12 MAIDEN NAME OF MOTHER

Salome Mildred Batton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

MO

14 Informant From birth certificate
(Address)

15 Filed June 26 John Houghlin
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 25 19 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

3-25-, 19 26, to 3-25-, 19 26.

that I last saw him alive on 3-25-, 19 26.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Ro. Jennings, M. D.

3-26-, 19 26 (Address) Pullman

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

RECEIVED JUN 12 1926

19 Place of Burial, Cremation, or Removal Date of Burial
19

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

5594 01-005-1538

PLACE OF BIRTH

RECEIVED

MAR 12

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Benedict

City of Plummer

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 46 State File No. 140288

Hospital _____ Primary Registration District No. 2123 Local Registrar's No. 5

FULL NAME OF CHILD Martine Vercoe

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? ✓ and { Number in order of birth 8 Legitimate? yes Date of birth Feb 1 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 7

FULL NAME FATHER Sam Vercoe

RESIDENCE Plummer, Idaho

COLOR white AGE AT LAST BIRTHDAY 48 (Years)

BIRTHPLACE Michigan

OCCUPATION Laborer

FULL MAIDEN NAME MOTHER Jaye Ethell

RESIDENCE Plummer, Idaho

COLOR white AGE AT LAST BIRTHDAY 36 (Years)

BIRTHPLACE Ill.

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn { 2 } at 3 a. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Feb. 1 1926

Registrar.

Registrar.

10-10-68

[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED

CERTIFICATE OF DEATH

52677

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 46
BUREAU OF VITAL STATISTICS
City Registration District No. 2123
(No. St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED,

single

6. DATE OF BIRTH.

Feb 1

26

(Month)

(Day)

(Year)

7. AGE

26

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Plummer, Ida

10. NAME OF FATHER

Samuel Vercos

11. BIRTHPLACE OF FATHER

(State or Country)

Iron Mountain, Mich

12. MAIDEN NAME OF MOTHER

Faye Ethel

13. BIRTHPLACE OF MOTHER

(State or Country)

Bloomington, Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Samuel Vercos

Plummer, Ida

15.

Filed

Feb 1 1926

W. G. Reiger
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 1

(Month)

(Day)

1926
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 1 1926 to Feb 1 1926

that I last saw h. alive on 191...

and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Premature delivery
stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Placenta previa in mother

(Duration) Yrs. mos. ds.

(Signed)

L. B. Clegg

M. D.

Feb 1 1926 (Address) Plummer

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... days

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Plummer, Ida

DATE OF BURIAL

Feb 1 1926

20. UNDERTAKER

Handled by Sam Vercos, father

ADDRESS

Plummer

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers, who receive a definite salary*) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

638-125-001-639
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada

City of Boral

No. 617 W N

Hospital SARH

RECEIVED
MAY 7

BUREAU OF VITAL
STATISTICS

St. Registrar's No. 2

CERTIFICATE OF BIRTH

State File No. 140311

Primary Registration District No. 1004 Local Registrar's No. 153

FULL NAME OF CHILD

Boy Oliver

(Certificate of no value without full name of child)

Sex of
Child

Boy

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate? ho

Date of
birth April 25 1926
(Month) (Day) (Year)

What bactericidal solution was used in eyes? —

Number of child of this mother, including present birth 1 — Number of child of this mother now living, including present birth 1 —

FULL
NAME

FATHER

Charles Brown

RESIDENCE

Horse Shoe Bend, Ida

COLOR

White

AGE AT LAST
BIRTHDAY

70
(Years)

BIRTHPLACE

OCCUPATION

Cattle Raiser

FULL
MAIDEN
NAME

MOTHER

Mary Ella Oliver

RESIDENCE

Idaho

COLOR

White

AGE AT LAST
BIRTHDAY 24
(Years)

BIRTHPLACE

OCCUPATION

Homestic

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 10 A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

S. S. S. S.

(Physician or midwife)

Address

Filed 4 30 1926

Registrar.

Registrar.

RECEIVED
MAY 19 1914
U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON, D.C.

MAY

IT IS A YEAR OF CHILD

of no value without full name of child

Twins
Original
or others
(To be answered only in case of plural births)

What particular relation was there in event

of child of this mother, including to second birth

Number of child of this mother now living including present

MOTHER

FATHER

FULL
NAME

RESIDENCE

RESIDENCE

AGE AT BIRTH

COLOR

PLACE OF BIRTH

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

On the day above stated
When there was no attending physician
I certify that the father, mother, or
other person present at the birth
gave me such evidence of the child's birth
as was required from a responsible person

(Signature of physician)

Physician

Registrar

Physician

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 7
STATE OF IDAHO
BUREAU OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **53098**

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 7
Primary Registration District No. 1094
(No. Salvation Army Rescue Home
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 111

2. FULL NAME

(a) Residence. No. 9 Baby Oliver St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m. 4 COLOR OR RACE w. 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Apr. 25, 1926

7 AGE Still Born Years 0 Months 0 Days 0 If LESS than 1 day, min. hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Boise, Ida.
(State or country)

10 NAME OF FATHER Charley Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ella Oliver

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Pearl Allene
(Address) Boise, Ida.

15 Filed 4-27-26 Robert N. Heath
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 25 1926
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Apr. 25, 1926, to Apr. 25, 1926, that I last saw him alive on none, and that death occurred, on the date stated above, at 10 am.
The CAUSE OF DEATH* was as follows:

Still Born

(duration) yrs. mos. ds.
CONTRIBUTORY Unknown
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Seigorney M. D.
4/26, 1926 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal County Cemetery Date of Burial 4/26 1926

20. Undertaker Wm Mc Bratney Address Boise, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

168-206-003-841
PLACE OF BIRTH

RECEIVED

MAY 3 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Carlisle

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No. — St. Registration District No. 84 State File No. 140368

Hospital — Primary Registration District No. 2/61 Local Registrar's No. 220

FULL NAME OF CHILD Infant Johnson

(Certificate of no value without full name of child)

Sex of Child female Twin Triplet or other? — and { Number in order of birth — Legitimate? yes Date of birth Jan 6, 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Walter M. Johnson
RESIDENCE Carlisle
COLOR white AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE mo.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Louise Johnson
RESIDENCE Carlisle
COLOR white AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Ida
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { born alive / Stillborn } at 12:10 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature) Russell Sigurd

(Physician or midwife)

Address Asa Springs, Idaho

Filed 7-10- 1926 Mr. J. J. Fitz

Registrar.

Registrar.

NO 9

981

(Classification of [redacted])

([redacted])

[redacted] child, who was [redacted]

[redacted]

([redacted])

DATE OF
BIRTH

(Date)

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Number of child in this category including present birth

[illegible]

(Certificate of No Value without the name of child)

No. _____
 Primary Postal Address: _____
 Secondary Postal Address: _____
 No. _____
 Residential Address: _____
 Local Post Office: _____

RECEIVED AT STATION TWO

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

345-110-003-345
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock
City of Shoshone Falls
No. 84
Hospital _____ Primary Registration District No. 2161
FULL NAME OF CHILD 710 name
(Certificate of no value without full name of child.)

Sex of Child male Twins and Number in order of birth 1st Legitimate? yes Date of birth 2-10-1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>Jens Lund</u>	FULL MAIDEN NAME	<u>Hilda Lundquist</u>
RESIDENCE	<u>Grace</u>	RESIDENCE	<u>Grace</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>27</u> (Years)	AGE AT LAST BIRTHDAY	<u>16</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 2 P. M.
on the date above stated Premature Cause unknown (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Russell Tignor

(Physician or midwife)

Give names added from a supplemental report.

Address Soda Springs

Filed Apr 11 1926

Registrar.

Registrar.

Copy of

THE STATE OF NEW YORK
County of ...
Primary Registration District No. ...

(Signature of the registrant)

Number of birth ...
Date of birth ...
Place of birth ...
Last name ...
First name ...
Middle name ...

MOTHER
NAME
RESIDENCE

COLOR
BIRTHDAY
OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Address
Physician
Signature
Date

RECEIVED

MEDICAL CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BannockCity of Turner (No. 716 name)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Register District No. 84

BUREAU OF VITAL STATISTICS

District No. 2161

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 53124Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Feb-10-
(Month)

(Day)

26
(Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jens Lund

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Hilda Lundquist

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Meta Lund
Grace

(Address)

15.

Filed 4/30- 1926Mrs. J. J. Fitz

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb-
(Month)10-
(Day)26
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 10, 1926 to 19that I last saw him alive on Feb 10 1926and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Stillborn - Premature
cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Russell Smith M. D.19 (Address) Soda Springs, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.*; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

345710-003-345
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock **RECEIVED**
City of Grace **MAY 3 1926**
No. 84 **BUREAU OF VITAL STATISTICS** File No. 140372
Hospital Primary Registration District No. 2161 Registered No. 224
FULL NAME OF CHILD 716 name
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin <u>twins</u> and <u>2nd</u> Triplet or other? <u> </u> (To be answered only in event of plural births)	Number in order of birth <u>2nd</u>	Legitimate? <u>yes.</u>	Date of birth <u>2-18-1926</u> (Month) (Day) (Year)
--------------------------	--	-------------------------------------	-------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER FULL NAME <u>Jesse Lund</u> RESIDENCE <u>Grace</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>27</u> (Years) BIRTHPLACE <u>Idaho</u> OCCUPATION <u>Farmer</u>	MOTHER FULL MAIDEN NAME <u>Hilda Lundquist</u> RESIDENCE <u>Grace</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>16</u> (Years) BIRTHPLACE <u>Utah</u> OCCUPATION <u>Housewife</u>
---	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at on the date above stated (Born alive or stillborn) 216 P. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Russell Fisher

(Physician or midwife)

Give names added from a supplemental report.

Address Inda Springs

Filed Apr 11 1926 Mrs. E. J. Fish
Registrar.

8
HIVIS TO REPORTING OFFICE

DATE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

DATE OF BIRTH

Place of
birth

Height
Weight

Number
of
births

Sex

NAME

NAME

NAME

NAME

NAME

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

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DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Barnock
City of Grace Turner

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED MEDICAL CERTIFICATE OF DEATH

Registration District No. 84
BUREAU OF VITAL STATISTICS
District No. 2161
City of IdahoState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 53123Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Feb - 10 - 1926
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Meta Lund(Address) Grace Ida

15.

Filed 4/301926Mrs. J. J. Felt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb - 10 - 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 10, 1926 to 1926
that I last saw him on Feb. 10, 1926,
and that death occurred on the date stated above, at 7:10 A.M.

The CAUSE OF DEATH* was as follows:

Stillborn - Premature - Cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Russell T. Felt M. D.19. (Address) Idaho Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the ~~latter statement~~; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
695 715 006-249
County of Bingham MAY
City of Blackfoot BUREAU
No. Thomas St. Registration District No. 121 State File No. 140446
Hospital _____ Primary Registration District No. 2194 Local Registrar's No. 122
FULL NAME OF CHILD Elmer Wiese

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legiti- mate? yes Date of birth April 15 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME

Max Wiese

RESIDENCE

Blackfoot, Idaho # 2

COLOR

White

AGE AT LAST

33

BIRTHDAY

(Years)

BIRTHPLACE

Neb.

OCCUPATION

Farmer

MOTHER
FULL MAIDEN NAME

Katie Burk

RESIDENCE

Blackfoot, Idaho #2

COLOR

White

AGE AT LAST

29

BIRTHDAY

(Years)

BIRTHPLACE

Wis

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was (Born alive) at Blackfoot 5.30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. W. W. W. W.

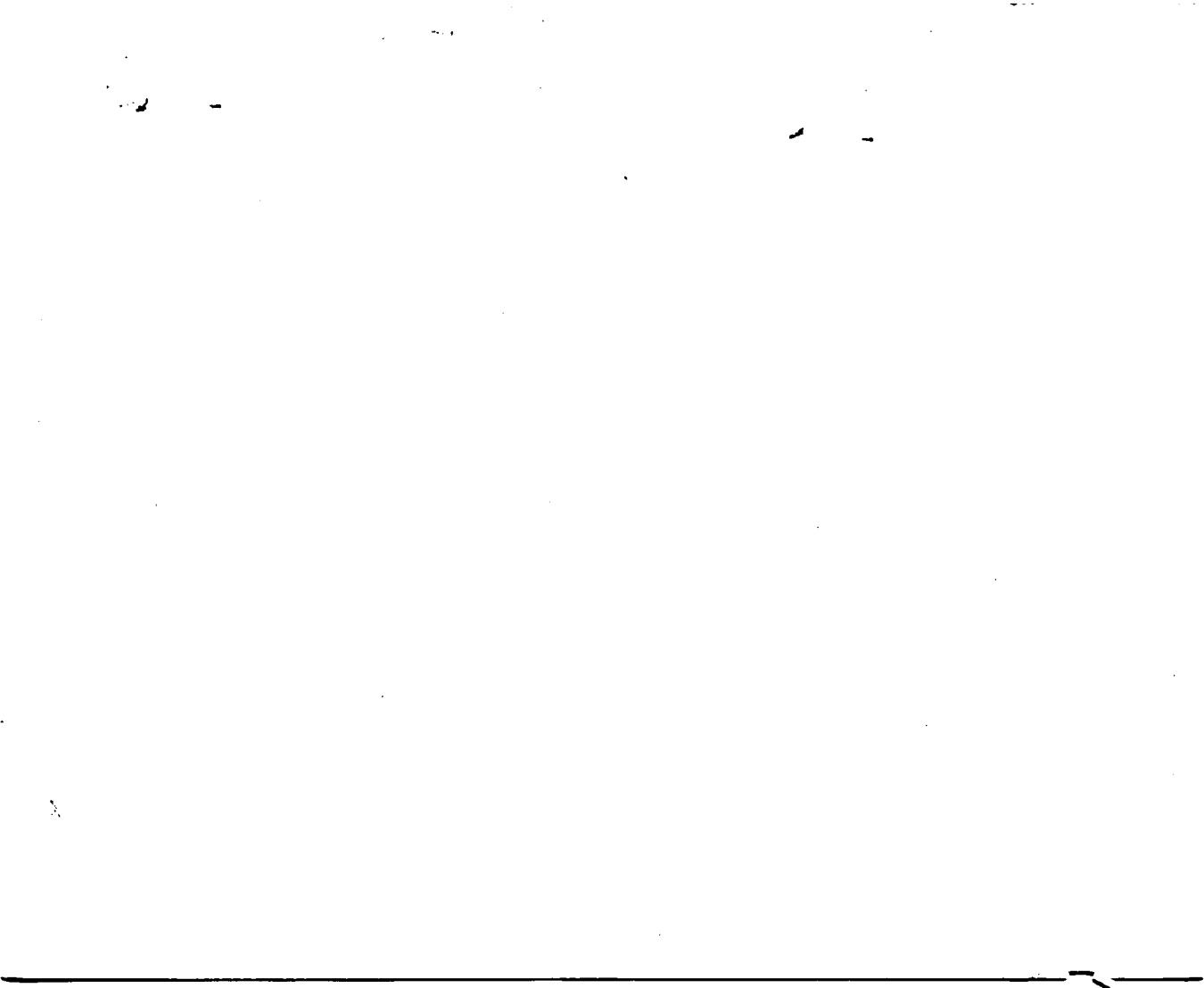
(Physician or midwife)

Address Blackfoot

Filed May 4 1926

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
MAY 6 BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 53146

Local Registrar's No. 51

PLACE OF DEATH **BUREAU OF VITAL STATISTICS**
County of Blackfoot District No. 151
City of Bingham Primary Registration District No. 1007
(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elmer Wiese

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Still born

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Blackfoot
(State or country) Idaho

10 NAME OF FATHER Max Wiese

11 BIRTHPLACE OF FATHER (city or town) Nebraska
(State or country)

12 MAIDEN NAME OF MOTHER Katie Burke

13 BIRTHPLACE OF MOTHER (city or town) Wisconsin
(State or country)

14 Informant Max Wiese
(Address) Blackfoot Idaho. R. 3

15 Filled Apr 16 1926 McClintock Registrar

MEDICAL CERTIFICATE OF DEATH fab

16 DATE OF DEATH April 15 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April-15, 1926, to April 15, 1926,
that I last saw deceased on April-15, 1926,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Born

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Tubercular mother
(Secondary)

(duration) 5 yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) H. Amick M. D.
4/16, 1926 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Grove City Cemetery Date of Burial 4-16 1926
20 Undertaker E. L. Egli Address Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

863-122-009-469

County of Permit

City of Grand Rapids

No. _____ St. _____

Hospital

FULL NAME OF CHILD.....

RECEIVED

MAY 7

BUREAU OF VIT **CERTIFICATE OF BIRTH**
STATIST

Registration District No. 78 State File No. 100-100000

Primary Registration District No. 2153 Local Regis

.....

Certificate of no sale without full name of child)

Sex of Child

Twin Triplet or other?

and { Number
in order
of birth

Legitimate?

Date of birth.....

182. (

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

**FULL
NAME**

FATHER

**FULL
MAIDEN
NAME**

MOTHER

RESIDENCE**RESIDENCE**

COLOR

AGE AT LAST BIRTHDAY 23
(Years)

COLOR

AGE AT LAST BIRTHDAY 23
(Years)

BIRTHPLACE**BIRTHPLACE**

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 230 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

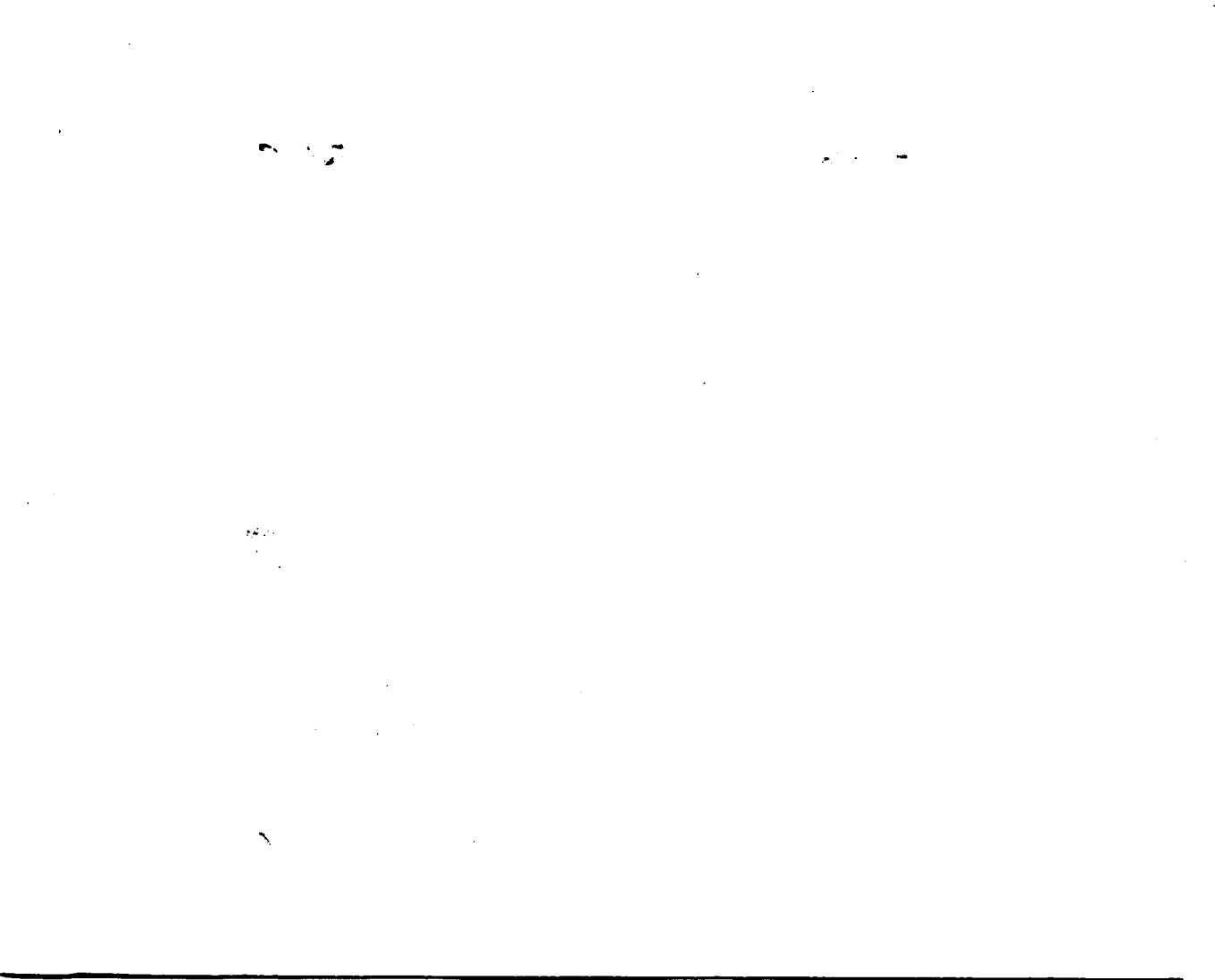
(Physician or midwife)

Address

Filed May 4 1926

Viola Allen
Deputy Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
MAY 7 1926
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

County of Bonner
City of Sandpoint
District No. 78
Registration District No. 2155

DO NOT WRITE IN THIS SPACE

State File No. 53160

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Hollingworth

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M
non sex
4 COLOR OR RACE white
5 Single, Married, Widowed, or Divorced (write the word) single

16 DATE OF DEATH
April 22 1926
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1926 to 19
that I last saw him alive on Bonner, 19____,
and that death occurred, on the date stated above, at _____ m.

6 DATE OF BIRTH (month, day and year) April 22, 1926

The CAUSE OF DEATH* was as follows:

7 AGE Still born
Years Months Days 1 If LESS than day, hrs. or min.

Still born
7 1/2 mo gestation
(duration) yrs. mos. ds.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY Even work
(Secondary) (duration) yrs. mos. ds.

9 BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

18 Where was disease contracted
If not at place of death?

10 NAME OF FATHER Hilton Hollingworth

Did an operation precede death? _____ Date of _____

11 BIRTHPLACE OF FATHER (city or town) Spencer County
(State or country) Nebraska

Was there an autopsy? _____

12 MAIDEN NAME OF MOTHER Winifred Morte

What test confirmed diagnosis?

13 BIRTHPLACE OF MOTHER (city or town) Marshall County
(State or country) Iowa

(Signed) L. E. Allen, M. D.

Apr 22, 1926 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14 Informant Hilton Hollingworth
(Address) R. F. D. 1 Sandpoint Idaho

19 Place of Burial, Cremation, or Removal Property of W. F. Hollingworth
near Poor farm Date of Burial Apr 24, 1926

15 Filled April 22, 1926 Viola Allen
deputy Registrar

20 Undertaker L. H. Moon Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cer-bro-spinal fever (the only definite synonym is "Epidemic cerëbrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

713-212-014-649

County of

City of

No.

Hospital

FULL NAME OF CHILD

RECEIVED
MAY 11 1926
BUREAU OF VITAL
STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 140571

Primary Registration District No. 3 State File No.

Local Registrar's No. 27

Infant Packwood - Stillborn
(Certificate of no value without full name of child)

Sex of Child Male } and { Number in order of birth } Legitimate? yes } Date of birth Apr. 12 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? No

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { ~~born alive~~ Stillborn } at 11-50 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Registrar.

Registrar.

Strangulation from
delayed delivery of
prolifers

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of Parma
City of Parma

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Confront - Packwood

RECEIVED

MAY 11 1926

BUREAU OF VITAL STATISTICS

Registration District No. 1007
(No. _____) (St. _____)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 53197
Local Registrar's No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

April 12 1924
(Month) (Day) (Year)

7. AGE

Supernatural
Yrs. _____ Mos. _____ ds. _____
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Parma Co., Idaho

10. NAME OF FATHER

Sam B. Packwood

11. BIRTHPLACE OF FATHER

(State or Country) Washington State

12. MAIDEN NAME OF MOTHER

Thelma L. Armstrong

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thelma L. Packwood
(Address) Parma, Idaho - R # 3

15.

Filed 510 19 26 Julius A. Lusk
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 12 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1926 to April 12 1926 that I last saw him alive on April 12 1926 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Strangulation from delayed delivery of placenta

(Duration) yrs. _____ mos. _____ ds.

Contributory (Secondary)

Difficult Labor

(Duration) yrs. _____ mos. _____ ds.

(Signed)

W. J. Muley M. D.

Apr. 19 26 (Address) Parma, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death yrs. _____ mos. _____ days. State yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma Cemetery Apr. 14 1926

20. UNDERTAKER

ADDRESS

Father of child Parma, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis**, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia RECEIVED
 City of Burley, Idaho APR 15
 No. 763 224016-763 Registration District No. 117 State File No. 140585
 Hospital St. Mary's State Registration District No. 2196 Local Registrar's No. 3337
 FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Girl</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u> }	Legitimacy <u>NO</u>	Date of birth <u>Mar. 24 1926</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>1</u>	Number of child of this mother now living, including present birth <u>0</u>
--	---

FATHER

FULL NAME Unknown

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

MOTHER

FULL MAIDEN NAME Bertha PollardRESIDENCE Burley, IdahoCOLOR WhiteAGE AT LAST BIRTHDAY 25

(Years)

BIRTHPLACE Longview, MissouriOCCUPATION Domestic wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2:45 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

G. H. Cooper M.D.
Physician & Surgeon
 (Physician or midwife)

Address

Burley, Idaho

Filed

4-1 1926 H. J. C. Patterson
 Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

W. P. H. H. H.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS				DO NOT WRITE IN THIS SPACE	
CERTIFICATE OF DEATH RECEIVED APR 10 1926 BUREAU OF VITAL STATISTICS				State File No. 53204	
PLACE OF DEATH County of <u>Cassia</u> City of <u>Burley</u>				Local Registrar's No. <u>835</u>	
District No. <u>117</u> Primary Registration District No. <u>2196</u>					
(No. _____) (If death occurred in a hospital or institution, give its name instead of street and number.)					
2. FULL NAME <u>Stillborn</u>					
(a) Residence. No. _____ St. _____ (Usual place of abode)					
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>		4 COLOR OR RACE <u>White</u>		5 Single, Married, Widowed, or Divorced (write the word) <u>Stillborn</u>	
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____					
6 DATE OF BIRTH (month, day and year)					
7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.					
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____					
9 BIRTHPLACE (city or town) <u>Burley, Ida.</u> (State or country)					
10 NAME OF FATHER <u>Unknown</u>					
11 BIRTHPLACE OF FATHER (city or town) (State or country) _____					
12 MAIDEN NAME OF MOTHER <u>Bertha Pollard</u>					
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <u>Mo. Longview</u>					
14 Informant <u>Bertha Pollard</u> (Address) <u>Burley, Ida.</u>					
15 Filled <u>Mar 24, 1926</u> <u>Dr. J. C. Patterson</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Mar 24</u> 19 <u>26</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY , That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Stillborn</u>					
_____ (duration) _____ yrs. _____ mos. _____ da.					
CONTRIBUTORY _____ (Secondary)					
_____ (duration) _____ yrs. _____ mos. _____ da.					
18 Where was disease contracted if not at place of death? _____					
Did an operation precede death? _____ Date of _____					
Was there an autopsy? _____					
What test confirmed diagnosis? _____					
(Signed) <u>G. H. Cooper</u> M. D. <u>Mar 24, 1926</u> (Address) <u>Burley, Ida.</u>					
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
19 Place of Burial, Cremation, or Removal <u>Burley, Ida.</u>				Date of Burial <u>Mar 24, 1926</u>	
20. Undertaker <u>none</u>				Address _____	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

STATE OF IDAHO

S

County of Cassia

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Burley Ida

APR 15

CERTIFICATE OF BIRTH

No. 25570508-593St. Registration District No. 117State File No. 140586Hospital 593Primary Registration District No. 2196 Local Registrar's No. 3338FULL NAME OF CHILD Deeban

(Certificate of no value without full name of child)

Sex of Child

BoyTwin
Triplet
or other?} and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?YesDate of
birthMar 5 1926
(Month) (Day) (Year)What bactericidal solution was used in eyes? argyrol sol.Number of child of this mother, including present birth 7Number of child of this mother now living, including present birth 6FULL
NAME

FATHER

George C. Keen

RESIDENCE

Burley Ida

COLOR

WhiteAGE AT LAST
BIRTHDAY55
(Years)

BIRTHPLACE

St. Johns Mich.

OCCUPATION

Spoket.FULL
MAIDEN
NAME

MOTHER

Minnie Nickelson

RESIDENCE

Burley, Ida.

COLOR

WhiteAGE AT LAST
BIRTHDAY29
(Years)

BIRTHPLACE

Mountain Green Ida

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was born at 11 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

G. H. Cooper M.D.
Physician and Surgeon
(Physician or midwife)

Address

Burley, Ida.Filed 4-1

192

D. J. C. Patterson

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

5 1/2 mo
1 wk

no 7

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
258 112 018 799
County of Clearwater.
City of Weippe, Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
MAY 6 1926

S

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
No. _____ St. _____ Registration District No. 90 State File No. 140608
Hospital _____ Primary Registration District No. 2168 Local Registrar's No. 36
FULL NAME OF CHILD Unnamed.

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes.</u>	Date of birth <u>April 12th 1926</u> (Month) (Day) (Year)
-----------------------------	---	--------------------------------------	----------------------------	---

What bactericidal solution was used in eyes? Argyrol.

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Milton SNyder.
RESIDENCE Weippe, Ida.
COLOR White. AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Idaho.
OCCUPATION Laborer.

MOTHER
FULL MAIDEN NAME Marie Pritchard.
RESIDENCE Weippe, Ida.
COLOR White. AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE W. Va.
OCCUPATION House wife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 2:00 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. M. Fairly
Physician.
(Physician or midwife)

Address Orofino, Ida.

Filed May 1st 1926

Registrar.

Registrar.

1. CHILD NOT REGISTERED HERE. RETURNED TO THE
PLACE OF ORIGIN OR TO THE PLACE OF RESIDENCE
OF THE PARENTS OR TO THE PLACE OF RESIDENCE
OF THE CHILD.

Give names and date of registration report
I have observed the name of the child
and should make this report. A statement
should be made that the child is not
known there was no attending physician
on the date of birth.

Register
125

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at 2:00 P.M.

Physician
(Signature or Title)

Address

Filed May 1st 1911

REGISTRATION

BIRTHPLACE

COLOR

RESIDENCE

Wife, Mrs.

FATHER

FULL
MAIDEN
NAME

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

MOTHER

Wife, Mrs.

Wife, Mrs.

BIRTHDAY

(Year)

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

Wife, Mrs.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **53205**

1. PLACE OF DEATH.

Registered District No. **90**County of **Clearwater**BUREAU OF VITAL STATISTICS District No. **2168**City of **Weippe**(No. **128**)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Un-named**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white**Single**
(Write the word.)

6. DATE OF BIRTH

April 12 1926
(Month) (Day) (Year)**12 1926**
(Day) (Year)

7. AGE

✓ yrs. ✓ mos. ✓ ds.IF LESS than 1 day
how many **h.** or **m.** or **min.**

8. OCCUPATION

(a) Trade, profession or

particular kind of work **none**

(b) General nature of industry

business, or establishment in

which employed (as employer) **none**

9. BIRTHPLACE

(State or Country) **Weippe, Ida.**10. NAME OF FATHER **Milton Snyder**11. BIRTHPLACE OF FATHER **Ida.**

(State or Country)

12. MAIDEN NAME OF MOTHER **Marie Britchard**13. BIRTHPLACE OF MOTHER **W. Va.**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Milton Snyder**(Address) **Weippe Ida.**

15.

Filed **May 1 1926**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 12 1926
(Month) (Day) (Year)**12**
(Day)**1926**
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 12 1926 to **April 12 1926**that I last saw him alive on **April 12 1926**and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Pneumonia (6 months)(Duration) **6 mos.** yrs. mos. ds.

Contributory

(Secondary)

(Duration) **6 mos.** yrs. mos. ds.(Signed) **J. M. Fairley**

M. D.

(Address) **Weippe Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VICARIOUS CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **6 mos.** yrs. mos. days. In the State **6 mos.** yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Weippe Ida**April 12 1926**

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED

MAY 10 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of IdahoCity of FernBUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

140677

No. 381109025-313St. Registration District No. 105 State File No.

Hospital

Primary Registration District No. 2183 Local Registrar's No. 17

FULL NAME OF CHILD

Still born child of Geo. Chase

(Certificate of no value without full name of child)

Sex of
ChildMaleTwin
Triplet
or other?} and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
birthApr 91926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

6

Number of child of this mother now living, including present birth

4FULL
NAME

FATHER

George Chase

RESIDENCE

Fern, Idaho

COLOR

White

AGE AT LAST

40

BIRTHDAY (Years)

BIRTHPLACE

Grangeville, Ida

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Mary E. Callan

RESIDENCE

Fern, Idaho

COLOR

White

AGE AT LAST

38

BIRTHDAY (Years)

BIRTHPLACE

S. Dakota

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 6 P. M.
on the date above stated.*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 1926

Registrar.

(Signature)

Wesley F. Orr M.D.

(Physician or midwife)

Address

Cottonwood, Ida

Filed

May 1 1926H. F. Orr per G.B.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

Edamprisa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED

MAY 10 1926

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Idaho
City of Idaho

BUREAU OF VITAL STATISTICS

District No. 105Registration District No. 2183State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 53234

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still born child - Geo. Chase

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

April 9 1926
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs. or
_____ min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George Chase

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary E. Callan

13. BIRTHPLACE OF MOTHER

(State or Country)

S. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

George Chase
Fenny Idaho

15.

Filed

May 1

1926

H. F. Orr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 9 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,
that I last saw h_____ alive on _____ 191____and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Still Born - due to
E. clamping

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) Wesley F. Orr M. D.3/9 1926 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Denver, Idaho Apr 10 1926

20. UNDERTAKER

ADDRESS

H. H. Schumacher Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

315-203-040-719
PLACE OF BIRTH

RECEIVED

MAY 6

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone

City of Kellogg

No. _____ St. _____

BUREAU OF CERTIFICATE OF BIRTH
STATISTICS

Registration District No. 123

File No. 140856

Hospital _____

Primary Registration District No. 2201

Registered No. 209

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twins Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth <u>10</u>	Legiti- mate? <u>yes</u>	Date of birth <u>4 3</u> (Month) (Day)	<u>1926</u> (Year)
----------------------------	--	--	-----------------------------	--	-----------------------

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Rich Canino
RESIDENCE Kellogg Ida
COLOR white AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Italy
OCCUPATION laborer

MOTHER
FULL MAIDEN NAME Mary Garcia
RESIDENCE Kellogg Ida
COLOR white AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Italy
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 8 A M.
on the date above stated. (born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. J. Friedman
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address Kellogg Ida

Filed Apr. 26 1926 Mrs. Helen M. Thorne

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

499-215-042-199 child's name added 12-23-87 lh
PLACE OF BIRTH STATE OF IDAHO
RECEIVED
DEPARTMENT OF PUBLIC WELFARE
COUNTY OF Twin Falls MAY 7
BUREAU OF VITAL STATISTICS
CITY OF Buhl CERTIFICATE OF BIRTH
No. _____ St. Registration District No. 34 State File No. 140886
Hospital _____ Primary Registration District No. 2087 Local Registrar's No. _____
FULL NAME OF CHILD Dora Othella Miracle
(Certificate of no value without full name of child)
Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth 4-15-1926
(To be answered only in event of plural births) (Month) (Day) (Year)
What bactericidal solution was used in eyes? Argyrol
Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 3
FULL NAME FATHER Albert R. Miracle FULL MAIDEN NAME MOTHER Julia Miracle
RESIDENCE Buhl RESIDENCE Buhl
COLOR wht. AGE AT LAST BIRTHDAY 27 COLOR wht. AGE AT LAST BIRTHDAY 26
(Years) (Years)
BIRTHPLACE Idaho BIRTHPLACE Idaho
OCCUPATION Laborer OCCUPATION Housewife
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was born alive at 7:45 A. M. on the date above stated. Stillborn
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 192_____

Registrar.

(Signature) R. G. Jennings
(Physician or midwife)
Address Buhl, Ida.
Filed A-30 1926 J. H. Wapley Registrar.

7-22-87

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics, Standards and Local Health Services
AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of _____ }
County of _____ } ss.

SEP 17 1987

Certificate No. 140886
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of

birth

for unnamed female Miracle who was born on April 15, 1926
(Name on Original Certificate) (Was Born, Died, etc.) (Date of Event)
in Buhl, Twin Falls Co. are erroneous or were omitted:
(Place of Event)

ITEMS TO BE CORRECTED

FROM

TO

Full name of child	unnamed Miracle	Dora Othella Miracle

Subscribed and sworn to before me this 10th day of
September, 1987.

Notary Public, Diane M. Wake

Residing at Burley, Idaho

My commission expires 09/17/88

(Seal)

x Irene "Miracle" Hughes
Signature of Applicant
x Rt 4 265 Bouch Rd Burley
Street Address, City, State
Idaho

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____ }
County of _____ } ss.

(Must be completed _)

(Is not necessary XXX)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of
_____, 19____.

Notary Public, _____

Residing at _____

My commission expires _____

(Seal)

Supporting Signature

Street Address, City, State

Insurance identification card from Farmers Ins. Group dated Ja. 1973 gives name as Dora O Miracle.
Viewed by V.S.

Medical Progress Notes gives name as Miracle, Dora Othella Miracle - dated Sept. 13, 1977, first visit date (April 15, 1981 seen by Dr. Dan Nofziger) viewed by V.S.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

577-12-042-695 PLACE OF BIRTH		RECEIVED MAY 3 BUREAU OF VITAL STATISTICS		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		S	
County of <u>Twin Falls</u>		City of <u>Filer</u>		CERTIFICATE OF BIRTH			
No. _____		St. _____		Registration District No. <u>38</u>		State File No. <u>140894</u>	
Hospital _____		Primary Registration District No. <u>2086</u>		Local Registrar's No. _____			
FULL NAME OF CHILD <u>Not named.</u>		(Certificate of no value without full name of child)					
Sex of Child <u>M</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>4-12</u>	<u>1926</u>		
(To be answered only in event of plural births)				(Month)	(Day)	(Year)	
What bactericidal solution was used in eyes? <u>None</u>							
Number of child of this mother, including present birth <u>1</u>				Number of child of this mother now living, including present birth <u>1</u>			
FULL NAME FATHER <u>Charles L. Eggleston</u>				FULL MAIDEN NAME MOTHER <u>Dorothy Jean Wiman</u>			
RESIDENCE <u>Filer</u>				RESIDENCE <u>Filer</u>			
COLOR <u>W</u>		AGE AT LAST BIRTHDAY <u>23</u>		COLOR <u>W</u>		AGE AT LAST BIRTHDAY <u>21</u>	
		(Years)				(Years)	
BIRTHPLACE <u>Idaho</u>				BIRTHPLACE <u>Idaho</u>			
OCCUPATION <u>Harm Laborer</u>				OCCUPATION <u>Sten</u>			
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*							
I hereby certify that I attended the birth of this child, who was { Born alive } at <u>4:00 A. M.</u> on the date above stated. { Stillborn } at _____							
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }				(Signature) <u>John Houghlin</u>			
Give names added from a supplemental report. _____, 192_____				(Physician or midwife) _____			
Address <u>Twin Falls, Idaho</u>				Filed _____ 192_____			
Registar. _____				Registar. _____			

months
malformed galathea
needed.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED MAY 3 1926
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

53315

State File No.

Local Registrar's No.

PLACE OF DEATH Home
County of Filer Registration District No. 1
City of Filer Primary Registration District No. 1

(No. 1)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Eggleston

(a) Residence. No. 1 St. 1

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE w 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days
1 If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Idaho
(State or country)

10 NAME OF FATHER Charles Eggleston

11 BIRTHPLACE OF FATHER (city or town) Col.
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Jean Wren

13 BIRTHPLACE OF MOTHER (city or town) Kans
(State or country)

14 Informant Charles Eggleston
(Address) Filer Idaho

15 Filed Apr. 4 19 26 Adamsberry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 12 19 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) John H. Laughlin M. D.

4/12/26 19 26 (Address) Filer Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Filer Idaho Date of Burial Apr 14 19 26

20. Undertaker none Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

173-222-04424
PLACE OF BIRTH

RECEIVED

APR 16

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL

BUREAU OF VITAL STATISTICS

S

County of Washington

City of Weiser

No. _____ St. _____

Registration District No. 56

File No. 140924

Hospital _____

Primary Registration District No. 1010

Registered No. 28

FULL NAME OF CHILD still Born.

(Certificate of no value without full name of child.)

Sex of Child <u>Girl</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>3/22/1926</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME George Lewis Allen
RESIDENCE Linne

MOTHER
FULL MAIDEN NAME Clara Elizabeth Busch
RESIDENCE Weiser

COLOR white AGE AT LAST BIRTHDAY 39
(Years)

COLOR white AGE AT LAST BIRTHDAY 28
(Years)

BIRTHPLACE Idaho

BIRTHPLACE Oklahoma

OCCUPATION Laborer

OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 5 P.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. A. Lamm

(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Weiser, Idaho
Filed April 10th 1926 H. R. Russell
Re- _____

Placenta Praea

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH

County of *Washington*

City of *Idaho*
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. *56*Vital Statistics District No. *1010*

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. *53324*Registered No. *18*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH.

3 *22* *1926*
(Month) (Day) (Year)

7. AGE

still born
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Winn. Idaho*

10. NAME OF FATHER

Geo Lewis Allen

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Clara Elizabeth Bush

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Clara Allen*(Address) *Winn. Oregon*

15.

Filed *3123* *1926**M. R. Hamilton*

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 *22* *1926*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to *191*

that I last saw him alive on *191*

and that death occurred on the date stated above, at *191* M.

The CAUSE OF DEATH* was as follows:

Placenta previa
(Duration) Yrs. mos. ds.

Contributory

(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *F. A. Schmitt* M. D.

3-23-1926 (Address) *Winn. Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, In the State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Winn. Oregon

DATE OF BURIAL

3-23-1926

20. UNDERTAKER

Winn. Northern

ADDRESS

Winn. Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

693-116.00-866
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

140949

County of Ada

City of Boise

No. 1014 N. 19

Hospital _____

FULL NAME OF CHILD Maurice Wilson

RECEIVED

JUN 5

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

S

No. _____ File No. _____

Primary Registration District No. 1004 Registered No. 212

(Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>May 16</u> 192 <u>6</u> (Month) (Day) (Year)
------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? 1

Number of child of this mother, including present birth 10 Number of children of this mother now living, including present birth 6

FATHER
FULL NAME Thor R. Wilson

RESIDENCE Boise

COLOR H. AGE AT LAST BIRTHDAY 50 (Years)

BIRTHPLACE Idaho

OCCUPATION Stock Ranch

MOTHER
FULL MAIDEN NAME Jennie Hoffman

RESIDENCE Boise

COLOR H. AGE AT LAST BIRTHDAY 43 (Years)

BIRTHPLACE Iowa

OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____
on the date above stated. (Date) or stillborn

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. Johnson M. D.

Give names added from a supplemental report.

_____, 192____

Registrar.

(Physician or midwife)
Address Boise Ida

Filed 1-6 1926 R. N. Pratt
Registrar.

Small part of mother.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

RECEIVED

CERTIFICATE OF DEATH

County of Ada Registration District No. 2
City of Boise Registration District No. 1004

DO NOT WRITE IN THIS SPACE

53538

State File No.

Local Registrar's No. 136

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maurice Wilson(a) Residence. No. 1016 N. 19 St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boise Idaho
(State or country)10 NAME OF FATHER J. R. Wilson11 BIRTHPLACE OF FATHER (city or town) Boise Idaho
(State or country)12 MAIDEN NAME OF MOTHER Jessie W Hoffman13 BIRTHPLACE OF MOTHER (city or town) Iowa
(State or country)14 Informant J. R. Wilson
(Address) 1016 N. 19 St15 Filed 5-17, 1926 Robert H. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Stillborn
May (Month) 17 (Day) 1926 (Year)17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to May 16, 1926, that I last saw him alive on Stillborn, 19____, and that death occurred, on the date stated above, at ____ m. The CAUSE OF DEATH* was as follows:Stillborn
death in uterus probably one
to two weeks before labor.
(duration) ____ yrs. ____ mos. ____ ds.CONTRIBUTORY (Secondary) _____
(duration) ____ yrs. ____ mos. ____ ds.18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) N. M. Holman, M. D.
May 17, 1926. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial May 17 2620. Undertaker Sumner & Thib Address Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

251-168-001-168
PLACE OF BIRTH

RECEIVED
JUN 5
BUREAU OF VITAL
STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S 140978

County of Ada
City of Bow
No. _____ Registration District No. 2 State File No. _____
Hospital _____ Primary Registration District No. 1004 Local Registrar's No. 189

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>m</u>	Twin Triplet or other? <u> }</u>	and {	Number in order of birth <u> }</u>	Legiti- mate? <u>yes</u>	Date of birth <u>May 8, 1926</u> (Month) (Day) (Year)
-----------------------	--	-------	--	-----------------------------	---

What bactericidal solution was used in eyes? none (Pneumonia & early death)

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Harry Beaton
RESIDENCE 407 O'Fallon
COLOR W AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Wisconsin
OCCUPATION Linotype Operator

MOTHER
FULL MAIDEN NAME Christina Phelan
RESIDENCE 407 O'Fallon
COLOR W AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Iowa
OCCUPATION HW

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 4:10 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 192____

(Signature) Harold W. Stone
M.D.
(Physician or midwife)

Address Overland Blvd. 913
City May 15 1926 P.O. Box
Registrar. Registrar.

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		DO NOT WRITE IN THIS SPACE State File No. 53341 Local Registrar's No. 130	
RECEIVED PLACE OF DEATH Adasun CERTIFICATE OF DEATH County of Ada City of Boise Registration District No. 1004 Primary Registration District No. 1004 (No. _____) (If death occurred in a hospital or institution, give its name instead of street and number.)			
2. FULL NAME Baby Beaton (a) Residence. No. 407 O. Farrell St. (Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.		(If nonresident give city or town and State)	
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3 SEX m. 4 COLOR OR RACE w. 5 Single, Married, Widowed, or Divorced (write the word) Single	16 DATE OF DEATH May 8 1926 (Month) (Day) (Year)		
5a If married, widowed, or divorced HUSBAND of (or) WIFE of	17 I HEREBY CERTIFY, That I attended deceased from May 8 1926, to May 8 1926, that I last saw him alive on May 8 1926, and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows: Premature Birth		
6 DATE OF BIRTH (month, day and year) May 8, 1926 Age Still Born Years Months Days 1 day, 1 hr. or min.	CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.		
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer	18 Where was disease contracted if not at place of death? Did an operation precede death? no Date of Was there an autopsy? What test confirmed diagnosis? (Signed) 5/10/26 Harold W. Stone, M. D. (Address) Boise Idaho		
9 BIRTHPLACE (city or town) Boise, Idaho (State or country)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
10 NAME OF FATHER H. W. Beaton 11 BIRTHPLACE OF FATHER (city or town) Lexon, Wis. (State or country) 12 MAIDEN NAME OF MOTHER Christina Johnson 13 BIRTHPLACE OF MOTHER (city or town) Buffalo Center, Ia. (State or country)	19 Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial 5/10/26 20. Undertaker Wm McBratney Boise, Ida.		
14 Informant Pearl Allen (Address) Boise Idaho	15 Filed May 10 1926 R. H. Ball Registrar		

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc.; Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

256-228-003-236
PLACE OF BIRTH

STATE OF IDAHO

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

141055

S

County of Bannock

City of Pocatello

No. 26 St. Register No. 28 State File No. 284

Hospital Poca Genl Primary Registration District No. 216 Local Registrar's No. 284

FULL NAME OF CHILD Infant Snow

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>4-28</u> <u>1926</u> (Month) (Day) (Year)
----------------------------	----------------------------------	--	------------------------	---

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Ralph A. Snow
RESIDENCE Pocatello Idaho
COLOR wht AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Utah
OCCUPATION Barber

MOTHER
FULL MAIDEN NAME Maey Blakham
RESIDENCE Same
COLOR wht AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Idaho
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 9:30 a. m.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. , 1926

(Signature) [Signature]

(Physician or midwife)

Address Pocatello Idaho

Filed 7/1926 Registrar [Signature]

Registrar.

34-2

2-2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
MAY 19 BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 53392

PLACE OF DEATH

County of Bannock BUREAU OF VITAL STATISTICS
City of Idaho Falls Station District No. 28
Primary Registration District No. 2161
(No. General Hospital)

Local Registrar's No. 4800

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Snow

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

April 28 - 1926

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

Stillborn

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Idaho Falls
Idaho

10 NAME OF FATHER

Ralph A. Snow

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Mae Blayham

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Idaho Falls
Idaho

14

Informant
(Address)

Ralph A. Snow
Idaho Falls

15

Filed 4-29, 1926

J. H. Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 28
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Apr 27, 1926, to , 1926,
that I last saw h. alive on , 1926,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn - due to
long hard tedious labor
of "Labor Trauma".

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Long tedious labor
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) J. H. Young M. D.
4/29/26 1926 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Mountain View Cem

April 29, 1926

20. Undertaker

Address

Shumacher & Hall

Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

133-117.003-313
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

141064

County of Bannock
City of Grace

No. _____ St. _____ Registration District No. 84 File No. _____
Hospital _____ Primary Registration District No. 2161 Registered No. 235-

FULL NAME OF CHILD

Baty Allen

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>5-17-1926</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	--

What bacteriocidal solution was used in eyes? nothing

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FATHER
FULL NAME Loren P. Allen
RESIDENCE Grace, Idaho
COLOR White AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Mary Ellen Calhoun
RESIDENCE Grace, Idaho
COLOR White AGE AT LAST BIRTHDAY 34 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 6:0 A. M.
on the date above stated. (Stillborn or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. L. Fitz

(Physician or midwife)

Give names added from a supplemental report.

Address

Bancroft, Idaho

Filed

5/17-1926

Mrs. E. L. Fitz

Registrar.

Registrar.

(continued)

RECEIVED JUN 2 - 1926

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Statistics

1. PLACE OF DEATH

County of Bannock
City of GraceRegistration District No. 84
Primary Registration District No. 2161
(No. _____ St.)File No. _____
Registered No. 48If death occurs away from
usual residence, give facts
called for under special in-
formation.2. FULL NAME No name - AllenIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Single
(Write the word.)

6. DATE OF BIRTH

May - 17 - 1926
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min. ?
_____ Yrs. _____ Mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Grace, Idaho10. NAME OF
FATHERLorne P. Allen11. BIRTHPLACE
OF FATHER(State or Country) Utah12. MAIDEN NAME
OF MOTHERMary Ellen Colkins13. BIRTHPLACE
OF MOTHER(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lorne P. Allen
(Address) Grace Ida15. 5/17 - 1926 Mrs. G. G. Fitz
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May - 17 - 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May - 17 - 1926, to May - 17 - 1926
that I last saw him never lived after birth alive on _____ 19_____,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature - stillborn
About 6 months

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

G. G. Fitz M. D.
5/17 - 1926 (Address) Grace Ida*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Grace Ida

DATE OF BURIAL

5/17 - 1926

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

867-10004-795
PLACE OF BIRTH

RECEIVED JUN 4 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bear Lake
City of Parrish

CERTIFICATE OF BIRTH 141083

No. St. Registration District No. 5-2 State File No.

Hospital Primary Registration District No. 2136 Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Boy</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>2-1</u> 192 <u>6</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Levith Hays
RESIDENCE Parrish
COLOR W AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Parrish
OCCUPATION clerk

MOTHER
FULL MAIDEN NAME B. C. Emmett
RESIDENCE Parrish
COLOR W AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Levitt
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was born alive at Salmon on the date above stated. about 4:30 P.M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report., 192...

(Signature) Montgomery Dean

(Physician or midwife)

Address Montgomery Dean

Filed 6/11

1926

Registrar.

Registrar

They were the subject of each a
to "and" more than one child in the
ABLE BIVOLTY WITH CERTAINLY A
THIS IS A NEW STATE

1. The first step is to identify the problem. This involves understanding the nature of the problem, its scope, and its impact.

801.

Testimony

(9733422)

1

CERTIFICATE OF ATTENDING PHYSICIAN OF MILWAUKEE

DOCTRINE

93A-2047-1A

SECRET

COLORED

TO: SAC, SDA
ADMINISTRATIVE

— 35 —

44-38861-1000

894-000

1. The first of these is the fact that the majority of the population of the United States is now living in urban areas. This is a result of the process of urbanization, which has been going on since the beginning of the 20th century. The population of the United States has increased from about 100 million in 1900 to over 200 million in 1960. At the same time, the population of rural areas has decreased from about 100 million in 1900 to about 50 million in 1960. This has led to a concentration of the population in urban areas, which has had a profound effect on the economy and society.

Large ni beam was collected from the source and it

Large ni beam was collected from the source and it

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

695-107-004-643
PLACE OF BIRTH

RECEIVED JUN 4 - 1926
STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

141086

County of Bear Lake
City of Manpower
No. _____ St. _____ Registration District No. 52 State File No. _____
Hospital _____ Primary Registration District No. 2136 Local Registrar's No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Boy Twin Triplet or other? and { Number in order of birth Legiti- mate? Yes Date of birth 2-7 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of 1 of this mother, including present birth Number of child of this mother now living, including present birth 3

FATHER
FULL NAME J. Q. Winters
RESIDENCE Manpower 37
COLOR W AGE AT LAST BIRTHDAY (Years)
BIRTHPLACE Manpower
OCCUPATION Carpenter

MOTHER
FULL MAIDEN NAME D. C. Fuller
RESIDENCE Manpower
COLOR W AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Paris
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at Manpower 49 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Robert H. Winters

(Physician or midwife)

Address Manpower

Filed 6/11 1926

Registrar.

Registrar.

STATE OF NEW YORK
 COUNTY OF ALBANY
 CITY OF ALBANY
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

14108C

STATE OF NEW YORK
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Registration District No. _____ State File No. _____
 Hospital Identification Number No. _____ Local Registration No. _____

FULL NAME OF CHILD

Given name of child _____
 Surname of child _____
 Sex of child _____
 Date of birth _____
 Time of birth _____
 Place of birth _____
 (If the mother only, it must be stated)

What name, if any, was used in birth _____

Number of child of this mother now living including present birth _____

FATHER Full name _____
 Maiden name _____
MOTHER Full name _____
 Maiden name _____
 Residence _____

COLOR _____
BIRTHPLACE _____
OCCUPATION _____
AGE AT LAST BIRTH _____
AGE AT LAST BIRTH _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ of _____

(Signature) _____
 Address _____
 Date _____

On the date above stated, I personally certified that I attended the birth of this child, who was _____ of _____
 When there was no attending physician or midwife, then the father, mother, or other person, should make this return. A statement that the child is one that neither practices nor shows other evidence of the same, is not required.

Give names added from a supplemental report _____
 103

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

992-129,006-155
PLACE OF BIRTH

RECEIVED JUN 5 - 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

141161

County of Bingham
City of Druidville

CERTIFICATE OF BIRTH

S

No. _____ St. _____ Registration District No. 121 State File No. _____

Hospital _____ Primary Registration District No. 2194 Local Registrar's No. 135

FULL NAME OF CHILD He named - Rosemary

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>4-29</u> 192 <u>6</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Geo. H. Rosemary
RESIDENCE Woodville Ida.
COLOR white AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Logan Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Glady's Jensen
RESIDENCE Woodville Ida.
COLOR white AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Kaysville Utah
OCCUPATION Housekeeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5 - - P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Edwin Arthur M.D.

(Physician or midwife)

Address Shelley Ida

Filed May 7 1926 M. L. Valente, Father

Registrar.

Registrar.

THIS IS A CERTIFICATE OF BIRTH AND NOT A DEED. IT IS NOT VALID UNLESS IT IS FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA. IT IS NOT VALID UNLESS IT IS FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA.

PLACE OF BIRTH

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
STATE OF MARYLAND

CERTIFICATE OF BIRTH

2

No. 100 Registration District No. 100 State File No. 100

Hospital St. Elizabeth's Primary Registration District 100 Local Registration No. 100

LEGAL NAME OF CHILD

(Certificate of no value without legal name of child)

Sex of Child Male

Time of Birth 10:00 AM

Month of Birth April

Day of Birth 10

Year of Birth 1900

(Year)

What antiseptical solution was used in event None

Number of child of this mother including present birth 1

Number of child of this mother including present birth 1

FULL NAME

FATHER

FULL MAIDEN NAME

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY (Years)

COLOR

AGE AT LAST BIRTHDAY (Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at home

Give names added from a supplemental report. When there was no attending physician or midwife, then the father, householder, etc. should make this return. A child is one that neither breathes nor shows other evidence of life after birth.

(Signature of midwife)

Witness

Filed 1900

Registrar

FORM V. S. No. 5-25 M. 1-19.

MAY 6

CERTIFICATE OF DEATH

1. PLACE OF DEATH **BUREAU OF VITAL STATISTICS** District No. 121
 County of Shoshone Primary Registration District No. 2194
 City of Shellywoodville, Ida. (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unmarried William Pismay

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 53150
 Registered No. 55

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH

4 29 1926
 (Month) (Day) (Year)

7. AGE

Still born
 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

still born

9. BIRTHPLACE

(State or Country) Woodville Ida.

10. NAME OF FATHER

Geo. H. Pismay

11. BIRTHPLACE OF FATHER

(State or Country) Laramie Utah

12. MAIDEN NAME OF MOTHER

Gladys Jensen

13. BIRTHPLACE OF MOTHER

(State or Country) Hyrum Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

George H. Pismay
R. 4 Idaho Falls

15.

Filed

April 30 1926 Ms Walter E. Pater

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 29 1926
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended/deceased from

during birth 19
 that I last saw h. alive on 19
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pregnatal separation of Placenta.

(Duration) Yrs. mos. 1/4 ds.
 Contributory (Secondary) Premature birth
 (Duration) Yrs. mos. about 7 months gestation ds.

(Signed)

Edwin Ruter M. D.

4/30 1926 (Address) Shellywoodville Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodville Cemetery 4-30-1926

20. UNDERTAKER

ADDRESS

none employed

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

154-241-506-295
PLACE OF BIRTH
County of Congham
City of Shelley Ida

RECEIVED JUN 5 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
141168

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 121 State File No. _____
Hospital _____ Primary Registration District No. 2194 Local Registrar's No. 142

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Female { Twin or other? } and { Number in order of birth } Legiti- Date of birth May 1 1926
mate? (Month) (Day) (Year)
(To be answered only in event of plural births)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Gordon Anderson
RESIDENCE Shelley Ida
COLOR W AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Lena Brewington
RESIDENCE Shelley Ida
COLOR W AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Cal
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 8:45 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

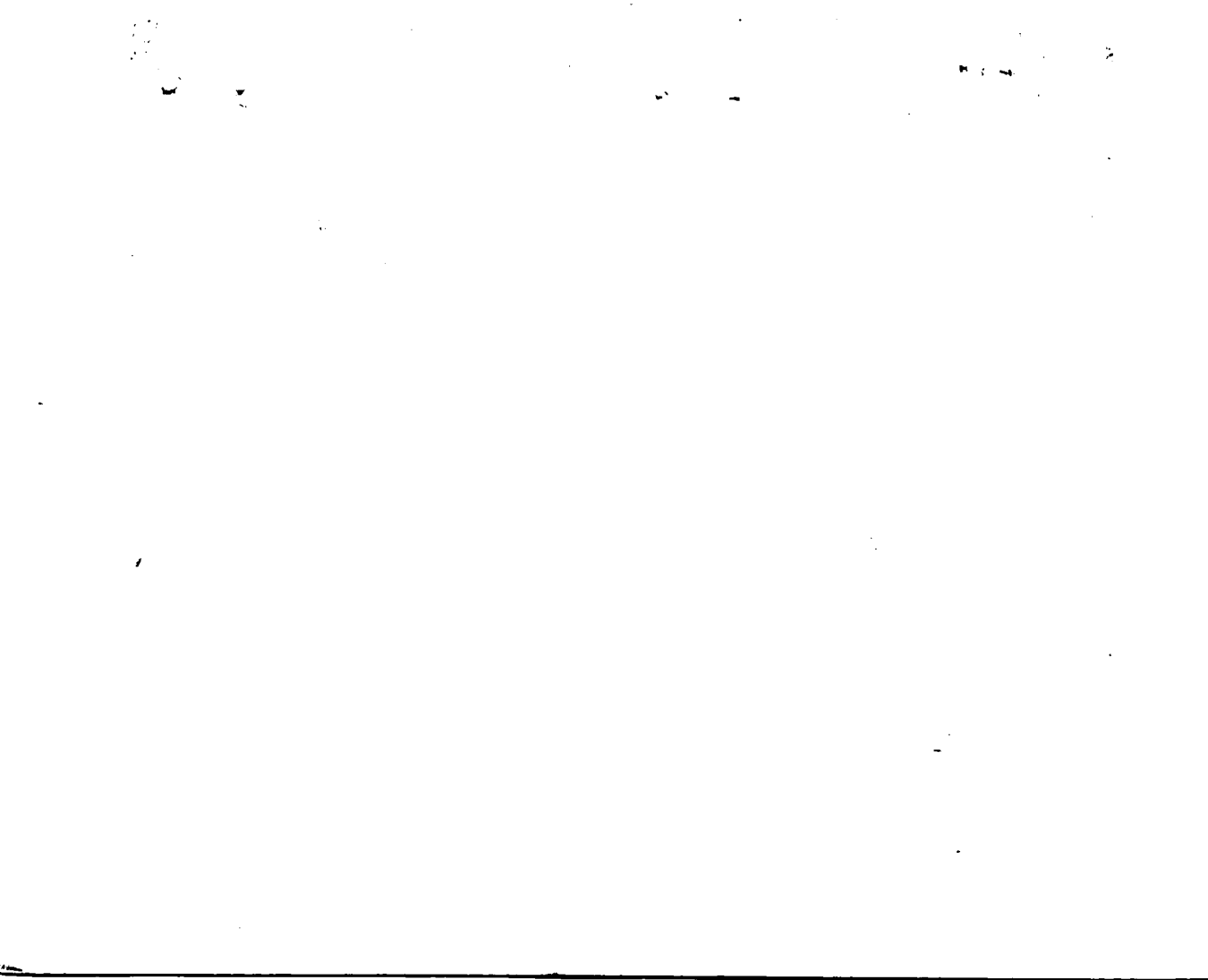
Physician or midwife

Address

Filed

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

POP-

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Franklin* Registration District No. *121*
City of *Franklin* Primary Registration District No. *2194* St.)

File No. *53402*
Registered No. *37*

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Madelin Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Infant*
(Write the word.)

6. DATE OF BIRTH *May 1 1926*
(Month) (Day) (Year)

7. AGE *Still born* IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*
(State or Country)

10. NAME OF FATHER *Gordon Anderson*

11. BIRTHPLACE OF FATHER *Idaho*
(State or Country)

12. MAIDEN NAME OF MOTHER *Lena Brevington*

13. BIRTHPLACE OF MOTHER *Calo*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Gordon Anderson*
(Address) *Franklin Idaho*

15. *May 3 1926*
Filed *McIntosh E. T. Allen*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH *May 1 1926*
Still born
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw him alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Not known

(Duration) Yrs. mos. ds.

Contributory (Secondary) Duration Yrs. mos. ds.

(Signed) *F. J. Roberts* M. D.
May 2 1926 (Address) *Shelley Id*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? *RECEIVED JUN 5 - 1926*

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Franklin Idaho* DATE OF BURIAL *May 3 1926*

20. UNDERTAKER *None Employed* ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

249-202-06-493
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

141180

S

County of _____

City of Blackfoot

No. _____ St. _____

Registration District No. 121

State File No. _____

Hospital _____

Primary Registration District No. 2194

Local Registrar's No. 154

FULL NAME OF CHILD Unnamed Burnett

(Certificate of no value without full name of child)

Sex of Child Female

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate? Yes

Date of
birth May 26

(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 2

FATHER
FULL NAME

FATHER

Alexander Burnett

RESIDENCE

Blackfoot, Ida

COLOR

White

AGE AT LAST
BIRTHDAY

41
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

MOTHER
FULL MAIDEN NAME

MOTHER

Anneta Miller

RESIDENCE

Blackfoot

COLOR

36

AGE AT LAST
BIRTHDAY

White

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1145 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) M. E. Petrie

(Physician or midwife)

Address Blackfoot, Idaho

Filed June 3 192 6

Registrar.

Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **53403**

Local Registrar's No. **58**

PLACE OF DEATH

RECEIVED
JUN 5 1926
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County of **Bingham** Registration District No. **121**

City of **Blackfoot** Registration District No. **2194**

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. **Blackfoot Idaho** St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

1 SEX **Female** 4 COLOR OR RACE **White** 5 Single, Married, Widowed, or Divorced (write the word) **S**

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) **May 2, 1926**

7 AGE **Years** Months Days **1** If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) **Bingham Co. 1 mi. N.E. of Blackfoot**

10 NAME OF FATHER **Alexander Barrett**

11 BIRTHPLACE OF FATHER (city or town) (State or country) **Idaho**

12 MAIDEN NAME OF MOTHER **Jessie Miller**

13 BIRTHPLACE OF MOTHER (city or town) (State or country) **Idaho**

14 Informant **Alexander Barrett Jr** (Address) **Blackfoot R.F.D. No. 3**

15 Filed **May 3 1926** Registrar **W. E. Pature**

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **May 2 1926**

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from **May 2 1926** to **May 2 1926** that I last saw him alive on **May 2 1926**

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Staphylococcus aureus - Used in return 2 days, Premature 8 months in culture duration of 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) **W. E. Pature M.D.**

May 3 1926 (Address) **Blackfoot Idaho**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal **Post City Cemetery** Date of Burial **May 4 1926**

20. Undertaker **Now employed** Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of **BONNER**

City of **PRIEST RIVER**

No. **IDAHO** St. **BUREAU OF VITAL**

Hospital _____

FULL NAME OF CHILD **Lily May Marshall**

(Certificate of no value without full name of child)

Sex of Child **F.** Twin Triplet or other? _____ } and { Number in order of birth _____ } Legitimate? **yes** Date of birth **April 3 1926** (Month) (Day) (Year)

What bactericidal solution was used in eyes? **Agar**

Number of child of this mother, including present birth **2**

FATHER FULL NAME **Ralph Marshall**

RESIDENCE **PRIEST RIVER**

COLOR **W.** AGE AT LAST BIRTHDAY **23** (Years)

BIRTHPLACE **Minn.**

OCCUPATION **Labare**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED

MAY 18

CERTIFICATE OF BIRTH

BUREAU OF VITAL STATISTICS

Primary Registration District No. **2145**

State File No. **141225**

Local Registrar's No. **429**

Local Registrar's No. **429**

Local Registrar's No. **429**

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Local Registrar's No. **429**

Local Registrar's No. **429**

Local Registrar's No. **429**

Local Registrar's No. **429**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was **Stillborn** at **4.40 P. M.** on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) **C. F. Gentry**

PRIEST RIVER

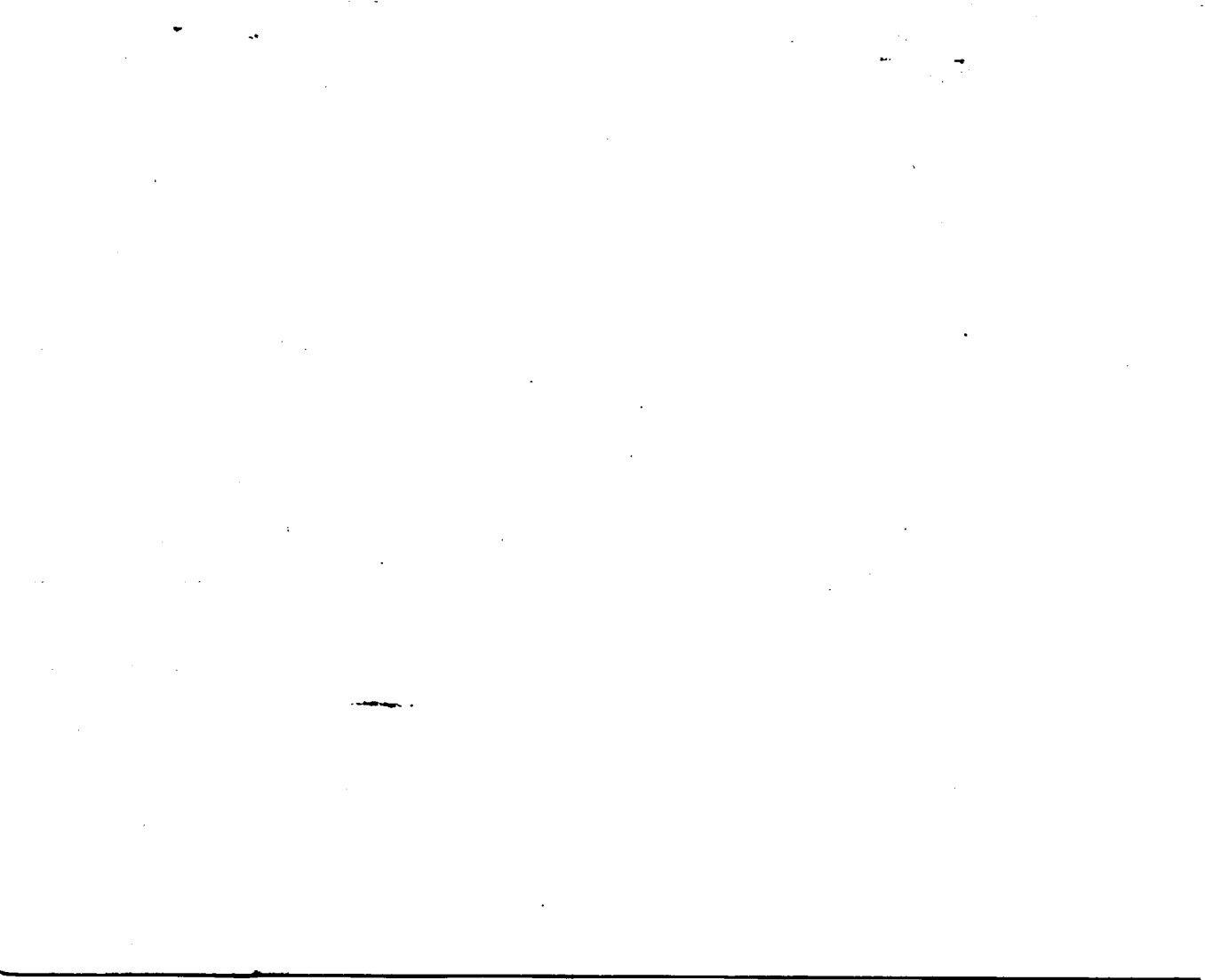
IDAHO (Physician or midwife)

Address _____

File **MAY 1 1926**

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 53445

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonner

Registration District No. 15

Local Registrar's No. 122

City of Priest River

Primary Registration District No. 2125

RECEIVED
MAY 18 1926
BUREAU OF VITAL STATISTICS

Deceased was confined in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant of Ralph Marshall

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da.

How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 3, 1926

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Priest River
(State or country) Idaho.

10 NAME OF FATHER

Ralph Marshall

11 BIRTHPLACE OF FATHER (city or town) Cloquett
(State or country) Minn.

12 MAIDEN NAME OF MOTHER

Viola Doolittle

13 BIRTHPLACE OF MOTHER (city or town) Vis.
(State or country)

14 Informant Ralph Marshall

(Address) Priest River, Ida.

15 Filed May 1, 1926

C. F. Gifford
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April
(Month)

3
(Day)

1926
(Year)

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1926, to —, 19—

that I last saw him alive on —, 19—

and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Still Born at 6 months

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. F. Gifford, M. D.

at 04, 1926 (Address) PRIEST RIVER

IDAHO

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

L. O. O. F. Cemetery
20. Undertaker

4/4 1926
Address

R. E. Wessa

Priest River

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

353213.009-685
PLACE OF BIRTH

RECEIVED JUN 5 - 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

141240

County of Bonne

City of Sandpoint

No. St.

Registration District No. 7.8

State File No.

Hospital

Primary Registration District No. 2.1.53

Local Registrar's No.

FULL NAME OF CHILD Infant Teller

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u>12</u>	Legitimate? <u>Yes</u>	Date of birth <u>5-13</u> 192 <u>6</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 12 Number of child of this mother now living, including present birth 12

FULL NAME <u>Leopold S Teller</u>	FATHER
RESIDENCE <u>Talache Id</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)
BIRTHPLACE <u>Mich.</u>	
OCCUPATION <u>Miner</u>	

FULL MAIDEN NAME <u>Erema H. Healy</u>	MOTHER
RESIDENCE <u>Talache Id</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Montana</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 11/15 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report., 192...

(Signature) E. J. O'Connell
(Physician or midwife)

Address Sandpoint Id

Filed June 3 1926 Viola Allen Deputy Registrar.

Registrar.

[illegible]

Give names and dates of supplemental report.
showed other members of the staff.
this is one that neither
etc. should make this report
or whether the latter is better
*When there was no all night

I attended the funeral of this child, who was 21 years of age.

Number of child of this mother, including present birth	Number of child of this mother, including present birth
FATHER	MOTHER
FULL MAIDEN NAME	FULL MAIDEN NAME
RESIDENCE	RESIDENCE
COLOR	COLOR
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

[illegible]

WILL NAME OF CHILD _____
(Certificate to be filled without full name of child)
Hospital _____
Previous Registration District No. _____
St. Registration District No. _____ State File No. _____

2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 53444

PLACE OF DEATH
County of Bonner
City of Talache

Registration District No. 28

Primary Registration District No. 2155

(No. _____)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Infant Teller

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

May 13, 1926

7 AGE

Years

Months

Days

1

if LESS than

day,

hrs.

or

min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Talache
Idaho.

10 NAME OF FATHER

Leighton S. Teller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Huron County
Michigan

12 MAIDEN NAME OF MOTHER

Emma Pearl Wheat

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Fort Benton
Montana

14 Informant

(Address)

Leighton S. Teller
Talache Idaho.

15 Filled

May 14, 1926

Viola Allen
Registrar

16 DATE OF DEATH

May
(Month)

13
(Day)

1926
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Stillbirth, 1926, to _____, 19____.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillbirth
Exhaustion 7 months

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

Unknown possibly during
in utero

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

7 (Signed) B. E. Alcorn M. D.

May 14, 1926 (Address) Sanford, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

RECEIVED JUN 5 - 1926

19 Place of Burial, Cremation, or Removal

Date of Burial

Lakeview Cemetery May 14, 1926

20 Under signer

Address

L. H. Brown Sanford, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy,"—"Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

155-125-231
PLACE OF BIRTH
RECEIVED
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Cassia
CITY OF Burley, Ida
No. 117 St. Registration District No. 117 State File No. 141386
Hospital Stillborn Primary Registration District No. 290 Local Registrar's No. 3360
FULL NAME OF CHILD Stillborn
(Certificate of no value without full name of child)
Sex of Child Boy Twin Triplet or other? and Number in order of birth 1 Legitimate? Yes Date of birth April 25, 1926
(To be answered only in event of plural births) (Month) (Day) (Year)
What bactericidal solution was used in eyes? Argyrol
Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth None
FATHER MOTHER
FULL NAME Frank L. Henney Maud Blake
RESIDENCE Burley, Ida Burley, Ida
COLOR White AGE AT LAST BIRTHDAY 46 (Years) White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Salt Lake City Utah Hooper Utah
OCCUPATION Laborer Housewife
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 P. M.
on the date above stated.
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 192____

Registrar. (Signature) G. H. Cooper M.D.
Physician or midwife
Address Burley, Ida
Filed May 1 1926 Dr. J. C. Patterson
Registrar.

FILED IN 100-443887

To be answered only in case of question
 { } and { }
 divided by }
 to be answered only in case of question

Number of child of this mother, including present birth

FATHER

第 2 次 1943 年 12 月

YADNEY
ABEAT

307941703

100-443886

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

in 1942 saw only this girl in dress of black and white, and I had never before

On the date above stated
 * When there was no attending physician
 or midwife then the father, householder
 etc. should make this return. A stillborn
 child is one that neither breathed nor
 shows other evidence of life after birth.
 Give names and from a supplemental report

1947

(S) b7C TO (S) b7D

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Minadosa
City of PaulIf death occurs away from
usual residence, give facts
called for under special in-
formation.Registration District No. 19Prim **RECEIVED** Registration District No. 2016
(No. MAY 1 St.)**BUREAU OF VITAL
STATISTICS**State File No. 53259Local Registrar's No. 4If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

no name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDwhite

(Write the word)

6. DATE OF BIRTH

4 - 25 - 1926
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Paul, Idaho10. NAME OF
FatherF. G. Wemyer11. BIRTHPLACE
OF FATHER

(State or Country)

Salt Lake City, Utah12. MAIDEN NAME
OF MOTHERMaudie Plate13. BIRTHPLACE
OF MOTHER

(State or Country)

Hooper, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul Idaho

15.

Filed April 26 1926 E. E. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April - 25 - 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillborn 19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH* was as follows:

= Born Dead =
anencephalus and
acrania
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. H. Cooper M. D.19 (Address) Burley, Ida*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days. State yrs. mos. ds.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Paul Idaho 4-26 1926

20. UNDERTAKER

W. E. Johnson Burley

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

319-228-016-385
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia

City of Burley

No. 117 District No. 117 State File No. 141388

Hospital Primary Registration District No. 2196 Local Registrar's No. 3367

FULL NAME OF CHILD Baby Larson

Stillborn Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>7/28/1926</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>James Larson</u>	<u>Burley</u>	<u>Carla E. Thestis</u>	<u>Burley</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>45</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Idaho</u>	OCCUPATION <u>Farmer</u>	BIRTHPLACE <u>Denver</u>	OCCUPATION <u>mother</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4/28/26 7 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. , 1926

(Signature) L. H. Gentry M.D.
Burley
(Physician or midwife)

Address Burley Idaho

Filed May 1 1926 Phy. C. Pattison
Registrar. Registrar.

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

N. B.—Every item of information should be carefully supplied. A true statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH RECEIVED

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 53514

County of Cassia MAY 18 1926
City of Burley Registration District No. 2195

Local Registrar's No. 844

2. FULL NAME Stillborn Larson

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

1926
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Butler M. D.

19 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

20. Undertaker

Address

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Apr 28 - 1926

7 AGE Years Months Days If LESS than
1 day, hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Burley Ida

10 NAME OF FATHER James Larson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Carla E. Thetstuen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Colo.

14 Informant Copied from birth certificate
(Address)

15 Filed May 19 26 Dr. J. C. Patterson
Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
 and the number of each, in order of birth stated.

265 115 020-269
 PLACE OF BIRTH

RECEIVED

MAY 24

STATE OF
 BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Elmore

City of Mtn Home

Registration District No. 37

File No. S 141445

No. _____ St. _____

Hospital _____

Primary Registration District No. 2020 Registered No. 15

FULL NAME OF CHILD

Stillborn, premature - 6 mos.

Sex of Child Male { Twin Triplet or other? (To be answered only in event of plural births) } and { Number in order of birth } Legitimate? Yes Date of Birth March 15 1926
 (Month) (Day) (Year)

FATHER
 FULL NAME Dave Bomacher
 RESIDENCE Mtn Home Ida
 COLOR White AGE AT LAST BIRTHDAY 29 (Years)
 BIRTHPLACE Wyoming
 OCCUPATION Laborer

MOTHER
 FULL MAIDEN NAME Eather H. Lamm
 RESIDENCE Mtn Home Ida
 COLOR White AGE AT LAST BIRTHDAY 24 (Years)
 BIRTHPLACE Idaho
 OCCUPATION _____

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11 A M.
 on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. E. Evans
M D
 (Physician or midwife)

Given names added from a supplemental report.

Address Mtn Home Ida
 Filed Apr 5 1926 Atkinson
 Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B. In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each in order of birth, stated.

S. F. No. 817

MAIL OR DELIVER
NOT TO THE

PLACE

Washington State Board of Health

Record No.

147559

County of Latah

BUREAU OF VITAL STATISTICS

Registered No.

City or Town of Genesee Id.

CERTIFICATE OF BIRTH

Registration Dist. No. 592-123029 813

Place of Birth near Genesee Id.

FULL NAME OF CHILD

READ

If child is not yet named do not delay filing this certificate. Name will be secured through supplemental report.

Sex of Child

Male

One
Twin
Triplet
or other?

and

Number in order of birth?

3rd

Legitimate?

Yes

Date of Birth

April 23

1926

Full Name

George Hibbler

FATHER

Residence

Genesee Id.

Color or Race

White

Age at last Birthday

25
(Years)

Birthplace

Idaho

(State or Country)

Occupation

Farming

Full Maiden Name

Nellie Hattup

MOTHER

Residence

Genesee Id.

Color or Race

White

Age at last Birthday

24
(Years)

Birthplace

Washington

(State or Country)

Occupation

Housewife

Number of child of this mother 3rd

Number of children, this mother, now living none

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.*

I hereby certify that I attended the birth of this child, who was born alive and that it occurred on

April 23, 1926, at 9 P.M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return.

(Signature)

Matthias J. Brey

(Physician or Midwife)

Give name added from a supplemental

report

Address

Montgomery Wash

Filed

May 1, 1926

Registrar

Registrar

† Indicate which by drawing line through superfluous word.

707

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

345 213 029 643
PLACE OF BIRTH

RECEIVED JUN 10 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah
City of MOSCOW
No. 908 S. Jefferson St.

CERTIFICATE OF BIRTH

141568

Registration District No. 601 File No. _____
Primary Registration District No. 1011 Registered No. 43

FULL NAME OF CHILD Elsie Cunningham

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	<u>Twins</u> Triplet or other?	} and {	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Apr. 13</u> 192 <u>6</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FULL NAME FATHER
Clarence Cunningham

FULL MAIDEN NAME MOTHER
Daisy Nina Fulton

RESIDENCE Moscow, Ida.

RESIDENCE Moscow, Ida.

COLOR White AGE AT LAST BIRTHDAY 25
(Years)

COLOR White AGE AT LAST BIRTHDAY 23
(Years)

BIRTHPLACE Orleans, Neb.

BIRTHPLACE San Dimas, Cal

OCCUPATION Farmer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born dead at 8:45 A.M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Harry Embury
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address Moscow, Ida.

Filed May 22 1926 M. H. Caruthers
Registrar.

Registrar.

DEPARTMENT OF COMMERCE
BUREAU OF STATISTICS

এই গ্রন্থ

— 5 —

HYPER TENSION

1941

..... 107

[illegible]

1940

biochemical inhibition of growth

1. *Chlorophyll a* (Chl *a*)

1. *Pharmaceutical industry*—United States—History.

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

1002

1

1. *Chlorophyll a* and *Chlorophyll b* were determined by the method of Arar and Collins (1971) using a Shimadzu 1010 spectrophotometer. The concentration of chlorophyll was expressed as $\mu\text{g mL}^{-1}$ of the sample.

Journal of Management Education 30(6)p.789-802
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1. *Chlorophyll a* and *Chlorophyll b* were determined by the method of Arar and Collins (1971) using a Shimadzu 1010 spectrophotometer.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

THE UNIVERSITY OF CHICAGO

no y

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

419 211029391
PLACE OF BIRTH

RECEIVED JUN 10 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

141570

County of Latah
City of Moscov
No. 141570 St.
Hospital _____

Registration District No. 101 File No. _____
Primary Registration District No. RIIF Registered No. 42

FULL NAME OF CHILD

Baby Baby

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>4-11-</u> 192 <u>6</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 0

FATHER
FULL NAME Irvin Haskell Barb
RESIDENCE Moscov, Idaho
COLOR White AGE AT LAST BIRTHDAY 35
(Years)
BIRTHPLACE Kansas
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Laura Trail
RESIDENCE Moscov, Idaho
COLOR White AGE AT LAST BIRTHDAY 34
(Years)
BIRTHPLACE Kansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 2:30 a. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Clifford O. Armstrong
Physician
(Physician or midwife)

Give names added from a supplemental report.

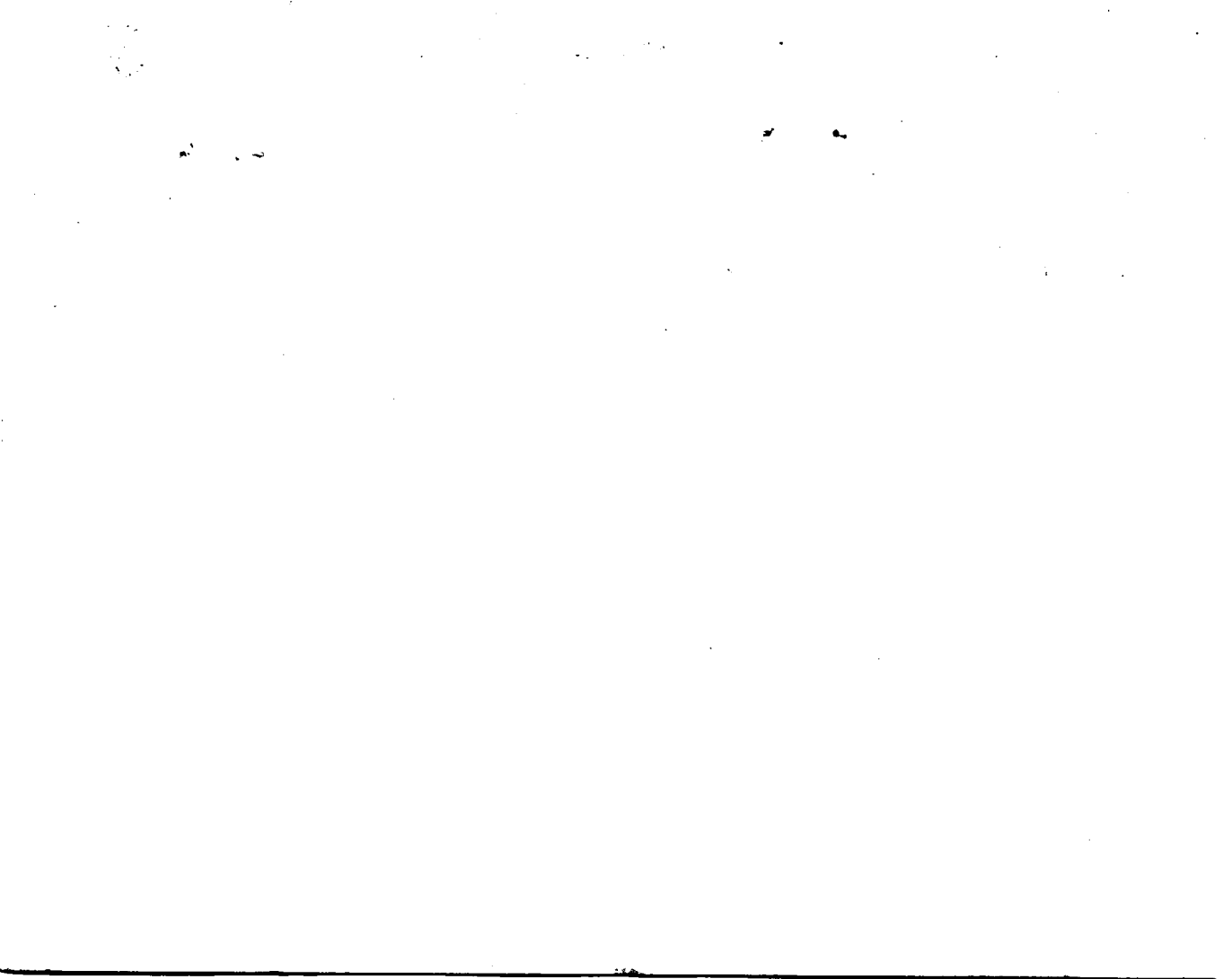
Address

Moscov, Idaho

Filed

May 7 1926 M. H. Cartthers
Registrar.

Registrar.



WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH.

County of Latah
City of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillbirth

RECEIVED

MAY 8 1926

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

Registration District No. 61Primary Registration District No. 1011

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 53251Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white

(Write the word.)

6. DATE OF BIRTH.

April 11 1926
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

F.H. Darby

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Laura Trail

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F.H. Darby

(Address) Moscow, Idaho

15.

Filed April 12 1926

W.H. Carithers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 11 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 11 1926 to Apr. 11 1926
that I did not see alive alive 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillbirth, probably
2 wks prior to birth
Bond at term.

(Duration) Yrs. mos. ds.

Contributory not known
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) W.H. Carithers M. D.

4/12/1926 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Southwick, Idaho

DATE OF BURIAL

4/12/26 191

20. UNDERTAKER

H.R. SHORT

ADDRESS

MOSCOW

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2018

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

284 216 033855

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Madison

City of Rexburg

RECEIVED
MAY 18
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

141587

No. District No. 111 State File No.

Hospital Primary Registration District No. 278 Local Registrar's No. 1434

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>April 16 1926</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? 2.90 mercuric chrome

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Henry N. Squires
RESIDENCE Rexburg, Idaho
COLOR White AGE AT LAST BIRTHDAY 34 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Harriette Della Hendrick
RESIDENCE Rexburg, Idaho
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 4:50 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) John S. Rich.

(Physician or midwife)

Address Rexburg Idaho

Filed 5-12 1926 141587

Registrar.

Registrar.

1. The mother of the child is a white female, aged 25 years, born at [illegible] on [illegible] 1900. She is married to [illegible] and has no other children. She is a native-born American citizen.

The mother stated that the child was born at [illegible] on [illegible] 1900. She stated that the child was born at [illegible] and was born at [illegible].

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was [illegible] at [illegible] on [illegible] 1900.

(Physician or midwife)
 Address [illegible]
 City [illegible]

(Signature) [illegible]

OCCUPATION [illegible]
 BIRTHPLACE [illegible]
 COLOR [illegible]
 AGE AT LAST BIRTHDAY [illegible]

RESIDENCE [illegible]

FULL NAME [illegible]

Number of child of this mother now living, including present birth [illegible]

MOTHER

OCCUPATION [illegible]
 BIRTHPLACE [illegible]
 COLOR [illegible]
 AGE AT LAST BIRTHDAY [illegible]

RESIDENCE [illegible]

FATHER

Number of child of this mother, including present birth [illegible]

What bacteriological solution was used to eyes? [illegible]

(To be answered only in case of a living birth)
 Sex [illegible] and [illegible]
 Length [illegible] weight [illegible]
 Date of birth [illegible] (Month) [illegible] (Day) [illegible] (Year) [illegible]

(Certificate of no value without full name of child)

WELL / ME OF CHILD

Hospital [illegible] Primary, Local District No. [illegible] Local Residence [illegible]

State file No. [illegible]

CERTIFICATE OF BIRTH

DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS

PLACE OF BIRTH

2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **53597**

Local Registrar's No. **275**

PLACE OF DEATH

County of **Madison** Registration District No. **100**
City of **Boise** Registration District No. **2178**

RECEIVED

CERTIFICATE OF DEATH

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **white** 5 Single, Married, Widowed, or Divorced (write the word) **Married**

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. **Still Born.**

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant

(Address)

15 Filed

4/16 19 **26**

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 16 19 **26**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **April 16** 19 **26**, to **4-16** 19 **26**, that I last saw h. **alive on** 19 **26**

and that death occurred, on the date stated above, at **11** m.

The CAUSE OF DEATH* was as follows:

Botulism from ovals

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

5/10 19 **26**

(Address)

John F. Rich M. D.

Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Boise - Ida.

4/17 19 **26**

20. Undertaker

Address

J. Young

Boise

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

753 202035-267
PLACE OF BIRTHRECEIVED JUN 10 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Terre PerceCity of Lewiston

No. _____ St. _____

Hospital WhitesRegistration District No. 96

File No. _____

Primary Registration District No. 1227

Registered No. _____

FULL NAME OF CHILD Baby Peters

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	<u>Twin</u> Triplet or other? } and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>MAY 2</u> 192 <u>6</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? borogyl 5%Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0FULL NAME FATHER Charles H. PetersRESIDENCE 938-3 ClarkstonCOLOR White AGE AT LAST BIRTHDAY 27 (Years)BIRTHPLACE Mont.OCCUPATION MerchantFULL MAIDEN NAME MOTHER Margaret BoggsRESIDENCE 938-3 Clarkston WtCOLOR White AGE AT LAST BIRTHDAY 22 (Years)BIRTHPLACE OhioOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 9:05 A. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. H. White M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address Lewiston IdahoFiled June 7 1926 Susan E Bruce

Registrar.

Registrar.

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

When not worn and found KNUTTER ALABAMA a United States and each person to wear it. It is
worn and in the United States and each person to wear it. It is

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. _____
Birth Date _____
Birth Time _____
Birth Place _____

Full Name of Child _____
Sex _____
Color _____
Weight _____
Length _____
Head _____
Chest _____
Arm _____
Leg _____
Foot _____
Finger _____
Nail _____
Hair _____
Eyes _____
Ears _____
Mouth _____
Nose _____
Skin _____
Tattoos _____
Scars _____
Birthmarks _____
Other _____

Number of children in family _____
Name of mother _____
Name of father _____
Name of child _____

Residence _____
Color _____
Birthplace _____
Occupation _____
Date at last _____
Time at last _____

Signature of attending physician _____
Date _____
Place _____

Signature of registrar _____
Date _____
Place _____

Signature of _____
Date _____
Place _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

53604

State File No.

Local Registrar's No.

PLACE OF DEATH

County of Boise
City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. 1)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Peters (Stillborn)

(a) Residence. No. Clarkston Ave St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 2nd 1926

7 AGE Years Stillborn Months Days 1 If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lewiston Idaho
(State or country)

10 NAME OF FATHER C. A. Peters

11 BIRTHPLACE OF FATHER (city or town) Montana
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Boggs

13 BIRTHPLACE OF MOTHER (city or town) Ohio
(State or country)

14 Informant C. A. Peters

(Address) Clarkston Ave

15 Filed June 7, 1926 Amos E. Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 2 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That, I attended deceased from May 2, 1926, to May 2, 1926, that I last saw him alive on May 2, 1926, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Still born
Premature placental
Separation
(duration) yrs. mos. ds.

CONTRIBUTORY Albuminuria of mother
(Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? apparent facts

(Signed) E. L. White M. D.
5-3, 1926 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

RECEIVED JUN 10 1926

19 Place of Burial, Cremation, or Removal Lewiston Ida Date of Burial 5/3 1926

20 Undertaker Brown - Wayne Co. Address Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

295-127040235

County of

City of Wallace

No. St. Registration District No. State File No.

Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD Stinson Hale

(Certificate of no value without full name of child)

Sex of Child <u>M</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legiti- mate? <u>Yes</u>	Date of birth <u>May 27</u> 192 <u>6</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FULL NAME <u>Hale Reed Sinclair</u>	FATHER
RESIDENCE <u>Wallace</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Indiana</u>	
OCCUPATION <u>Salesman</u>	

FULL MAIDEN NAME <u>Jae Stevenson</u>	MOTHER
RESIDENCE <u>Wallace</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>No Way</u>	
OCCUPATION <u>Yes</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 10:30 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

James R Bean MD

(Physician or midwife)

Address

Filed 192

Registrar.

Registrar. 77

believe that it is due to sodium and not to the

When there was no
inquiry, then the
should make this
and that better
showed the
proper language a

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

10-10-68

SECRET

AGE AT LAST
BIRTHDAY

১৯৭১/৭২

JUL 1975
EMAN

REVENUE

1/25/68

1979 of legal and judicial information and

1414)

1-10-77

IN REPLY TO

1994

ALBEN

INTRODUCTION

SECRET

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did to
leave. Learning he was

19

RENTOM

NAME
MADAM
NAME

30437:234

COLOR

BLMTHP/ACE

OCCLUSION

(Physician or midwife)

(2) (b) (7) (C)

SECRET

.SOF

Copy 13

39 240

...075

ESTABLISHED 1882

CONFIDENTIAL

Hospital _____

1950-1951

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Shoshone* Registration District No. *70*
City of *Wallace* Primary Registration District No. *1011*
If death occurs away from usual residence, give fact called for under special information. *Cypress St.*State File No. *53658*
Local Registrar's No. *88*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

D. R. Sinclair

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word)

6. DATE OF BIRTH

5-27-26
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many hrs. or min.?
Stillborn Mos. ds. min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE
(State or Country)*Idaho*10. NAME OF
Father*D. R. Sinclair*11. BIRTHPLACE
OF FATHER

(State or Country)

*Indiana*12. MAIDEN NAME
OF MOTHER*Fay M. Stevenson*13. BIRTHPLACE
OF MOTHER

(State or Country)

N. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. R. Sinclair

(Address)

Wallace, Idaho

15.

Filed *May 28* 19*26*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 27 1926
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *1896* to *1926*that I last saw him alive on *1926*
and that death occurred on the date stated above, at *10:30 p.m.*

The CAUSE OF DEATH* was as follows:

*Still born at 10:30 p.m.
May 27-1926*
(Duration) yrs. mos. ds.Contributory
(Secondary)(Signed) *James R. Bear* M. D.
19*26* (Address) *Wallace*

*State the Disease Causing Death; or in deaths from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or

usual residence

RECEIVED JUN 4 1926

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Wallace Idaho May 28 1926

20. UNDERTAKER

ADDRESS

W. C. Morrell Wallace

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S.

County of LetonCity of VictorNo. 395-105 041 355 St.Registration District No. 77State File No. 141734

Hospital

Primary Registration District No. 3176Local Registrar's No. 27

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

MTwin
Triplet
or other?} and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?+Date of
birth4/51926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 4Number of child of this mother now living, including present birth 3FULL
NAME

FATHER

Chas. Linsenmayer

RESIDENCE

Victor, Ida. U. S. A.

COLOR

WhiteAGE AT LAST
BIRTHDAY35
(Years)

BIRTHPLACE

Mo.

OCCUPATION

RancherFULL
MAIDEN
NAME

MOTHER

Mabel Revette

RESIDENCE

Ida.

COLOR

Do.AGE AT LAST
BIRTHDAY34
(Years)

BIRTHPLACE

Ida.

OCCUPATION

H. D.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (Born alive) Stillborn / at 10.00 a. m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. C. Redner, M.D.

(Physician or midwife)

Address

Triggs, Ida

Filed

5-31-1926Martha Marlar

Registrar.

Registrar.

STATE OF NEW YORK
 COUNTY OF ALBANY
 In SENATE
 January 11, 1911
 REPORT
 OF THE
 COMMISSIONERS OF THE LAND OFFICE
 IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
 MAY 11, 1909

STATE OF NEW YORK

CERTIFICATE OF MARRIAGE

Full Name of Bride _____
 Maiden Name of Bride _____
 Full Name of Groom _____
 Date of Marriage _____
 Place of Marriage _____
 (To be returned only in event of dissolution)

What persons were present at the ceremony?

Number of children born at the time of marriage _____

Number of children born since marriage _____

Number of children living at the time of marriage _____

Number of children living since marriage _____

Number of children living at the time of marriage _____

Number of children living since marriage _____

Number of children living at the time of marriage _____

Number of children living since marriage _____

Number of children living at the time of marriage _____

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Number of children living at the time of marriage _____

Number of children living since marriage _____

Number of children living at the time of marriage _____

Number of children living since marriage _____

Number of children living at the time of marriage _____

Number of children living since marriage _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of the child of _____

on the _____ day of _____ 1911.

At _____

_____ (Physician or Midwife)

Address _____

City _____

State _____

County _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
JUN 5
BUREAU
ST.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Letour
City of _____

Registration District No. 77
Primary Registration District No. 9176
(No. _____ St.)

File No. 53662
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE N 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH April 5- 1936
(Month) (Day) (Year)

7. AGE _____ Yrs. _____ Mos. _____ ds. _____
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION Infant
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Chas Linsenman

11. BIRTHPLACE OF FATHER mo
(State or Country)

12. MAIDEN NAME OF MOTHER Mabel Curtis

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Linsenman
(Address) Victor Idaho

15. 5-31- 1936 Martha Marker
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 5- 1936
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4th 1936 to April 5th 1936 that I last saw him alive on 19 and that death occurred on the date stated above, at Idaho.
The CAUSE OF DEATH* was as follows:

Still born

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L.T.T. Redner M. D.
4/5 1936 (Address) Augie, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Victor Cemetery DATE OF BURIAL 4-6- 1936

20. UNDERTAKER _____ ADDRESS _____

RECEIVED JUN 1 - 1926

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

234 120 003 397

PLACE OF BIRTH

RECEIVED JUL 10 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Pocatello

CERTIFICATE OF BIRTH

No. ✓ St. Registration District No. 28 State File No. 141957

Hospital Poca Genl Primary Registration District No. 2161 Local Registrar's No. 7650

FULL NAME OF CHILD Baby Sluder

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? ✓ and { Number in order of birth 1 Legitimate? yes Date of birth 6-20 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Gene R. Sluder
RESIDENCE Pocatello Idaho

MOTHER
FULL MAIDEN NAME Geneva Zipton
RESIDENCE same

COLOR whr AGE AT LAST BIRTHDAY 27 (Years)

COLOR whr AGE AT LAST BIRTHDAY 25 (Years)

BIRTHPLACE North Carolina

BIRTHPLACE North Carolina

OCCUPATION Laborer

OCCUPATION wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:30 p. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address Pocatello Idaho

Filed 7/1 1926 Registrar. [Signature]

Registrar.

[Faint, illegible handwritten text]

City of

1. Ishiguro

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

to 208
mid

WITNESSES:

redman's }
 white man }
 child to }
 to that could be made as also by

John
Latham

to find
... and
(1904)

(b) It is noted that neither name is to be obtained

What bacterial solution was used in 1961?

number of child of this mother, including present birth

RECEIVED

RESIDENCE

72-154704

DATE RECEIVED
BIRTHDAY

10-10-68

on right to slide to

MAIDEN
FULL

EMERSON

CONFIDENTIAL

1017

100

100-443887-100

[illegible]

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the trial on the date above stated.

When there was no attending physician or midwife, then the father, householder, or someone else, should make the return. A stillborn child is one that neither breathed nor had any movement of the after birth.

relative numbers of subjects in each category

100-443887-100

2891bA

১৩১৮

SECRET

ॐ नमः शिवायः

7-10-64

DEPARTMENT OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. 8-15-19

1. PLACE OF DEATH

County of Bannock
City of Poratello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 28

Primary Registration District No. 2161
(No. Poratello General Hosp. St.)

Infant Sluder

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 52763

Local Registrar's No. 4836

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

June 20 1926
(Month) (Day) (Year)

7. AGE

Still born

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Poratello

10. NAME OF
Father

Gene R. Sluder

11. BIRTHPLACE
OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME
OF MOTHER

Geneva Tipton

13. BIRTHPLACE
OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. R. Sluder

(Address)

Poratello Idaho

15.

Filed June 21 1926

McFarland
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 20 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19,
that I last saw h. alive on 19,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillbirth - (Eclampsia mother for 7 days)

(Duration) yrs. mos. ds.
Contributory (Secondary) Prematurity - Toxemia
Placental separation

(Signed) McFarland M.D.
Y. 1926 (Address) Poratello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence Poratello Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McFarland June 21 1926

20. UNDERTAKER

ADDRESS

McFarland & Co Poratello Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUL 1 - 1926 STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bear Lake

City of Genesee

No. 954725004-259 St.

Registration District No. 52

State File No.

149983

Hospital

Primary Registration District No. 2136

Local Registrar's No.

FULL NAME OF CHILD

Baby Redmon.

(Certificate of no value without full name of child)

Sex of
Child

Male

Twin
Triplet
or other?

} and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

June 25

1926

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

4

Number of child of this mother now living, including present birth

4

FULL
NAME

FATHER

Robert Leroy Redmon

RESIDENCE

Genesee

COLOR

White

AGE AT LAST

BIRTHDAY

41

(Years)

BIRTHPLACE

Missouri

OCCUPATION

Merchant

FULL
MAIDEN
NAME

MOTHER

Adelle Francis Kering

RESIDENCE

Genesee

COLOR

White

AGE AT LAST

BIRTHDAY

36

(Years)

BIRTHPLACE

Missouri

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

C. M. Badger

Physician

(Physician or midwife)

Address

Coperville, Wyo.

Filed

6/30/1926

Registrar.

Registrar.

CERTIFICATE OF BIRTH

Registration District No. 2

Prerogative Registration District No. 2

Full Name of Child

Comments of Registrar (without full name of child)

Sex of Child (Male) Date of Birth (1924) Month (Jan) Day (1) Year (1924)

Place of Birth (New York City)

Number of children of this mother and father (Total)

Full Name of Mother (Maiden Name) Full Name of Father

Color of Child (White) Birthplace (New York City) Occupation (Teacher) Age at Birth (1 year)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the date above stated.

When there was no attending physician or midwife, then the father, mother, or other person, should make this return. If the child is one year of age, the father, mother, or other person, should make this return. If the child is one year of age, the father, mother, or other person, should make this return.

(Signature of physician or midwife)

Address

102

U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 6-25 M. 1-19.

JUL 1 - 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bear Lake
City of GenovaRegistration District No. 52Primary Registration District No. 2136

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby RedmanState File No. 52781

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

June - 25 - 1926
(Month) (Day) (Year)

7. AGE

Still BornIF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF Father

Ruben LeRoy Redman

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Adelle Francis Gentry

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N. R. Redman

(Address)

Genova, Idaho

15.

6130119 26N. R. Kung

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June - 25 - 1926
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June - 25 - 1926 to June - 25 - 1926, that I last saw him alive on Still Born 19and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

PrematurityStill Born

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. M. Adams M. D.19 26 (Address) Coperville, Mo.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Genova, Ida.

DATE OF BURIAL

June - 26 - 1926

20. UNDERTAKER

Bishop

ADDRESS

Genova Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bear Lake

RECEIVED JUL 12 1926

City of Bloomington

CERTIFICATE OF BIRTH

No. 8937111004119 St.

Registration District No. 53

State File No. 141985

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate? Yes

Date of birth June 11 1926
(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 4

FATHER
FULL NAME

Leroy Isaac Hill

RESIDENCE

Bloomington Ida

COLOR

White

AGE AT LAST
BIRTHDAY 45
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

MOTHER
FULL MAIDEN
NAME

Ella Jarvis

RESIDENCE

Bloomington Ida

COLOR

White

AGE AT LAST
BIRTHDAY 45
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1.30 a. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

C. O. Moore M.D.
Paris Idaho
(Physician or midwife)

Address

Filed 6-20 1926

Mrs. J. L. Skinner
Registrar.

Registrar.

PLACE OF RECEIVED JUL 7 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of BinghamCity of Blackfoot

CERTIFICATE OF BIRTH 142028

No. 363-201006-557 St. 363-201006-557Registration District No. 121 State File No. 2124Hospital 363-201006-557Primary Registration District No. 204 Local Registrar's No. 204

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child FemaleTwin
Triplet
or other?} and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate? yesDate of birth June 1 1926
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2FULL
NAME

FATHER

Donald W. TolmieFULL
MAIDEN
NAME

MOTHER

Sophie Engelstead

RESIDENCE

Blackfoot, Idaho #3

RESIDENCE

Blackfoot, Idaho #3

COLOR

WhiteAGE AT LAST
BIRTHDAY 33
(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY 29
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Minn.

OCCUPATION

Farmer

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3.30.P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F. W. Mitchell

(Physician or midwife)

Address Blackfoot IdahoFiled July 4, 1926

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

P. acutilia *Frederick*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 7 1926
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 53785

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. _____)

Local Registrar's No. 70

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Unnamed Tolmie

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Girl 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 1 - 1926

7 AGE Years Months Days 1 If LESS than day, hrs. or min. ✓ ✓ ✓ ✓ 1 day, hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Blackfoot, Ida.
(State or country)

10 NAME OF FATHER Donald W. Tolmie

11 BIRTHPLACE OF FATHER (city or town) Ada Springs, Ida.
(State or country)

12 MAIDEN NAME OF MOTHER Opely Englestead

13 BIRTHPLACE OF MOTHER (city or town) Willmar, Minn.
(State or country)

14 Informant Donald W. Tolmie
(Address) Sheeley, Idaho

15 Filed June 1, 1926 W. W. Waters Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 1, 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1926 to June 1, 1926
that I last saw her alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Placenta Previa.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____
if not at place of death?

Did an operation precede death? NO Date of _____

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) D. W. Waters M. D.
June 1, 1926 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Fun City Cemetery Date of Burial June 1, 1926

20. Undertaker E. J. Turk Address Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

3651170091859
County of Bonner

City of Sandpoint

No. St. Registration District No. 7C State File No. 2

Hospital Primary Registration District No. 2153 Local Registrar's No.

FULL NAME OF CHILD Not named

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legiti- mately <u>Yes</u>	Date of birth <u>June 17</u> 192 <u>5</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? 2 not

Number of child of this mother, including present birth 2 not Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	<u>Vernon Longene</u>	FULL MAIDEN NAME	<u>Mary L. Linn</u>
RESIDENCE	<u>Sandpoint</u>	RESIDENCE	<u>Sandpoint Ida</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>24</u> (Years)	AGE AT LAST BIRTHDAY	<u>22</u> (Years)
BIRTHPLACE	<u>Ida</u>	BIRTHPLACE	<u>Ida</u>
OCCUPATION	<u>Clark</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 11 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) B. C. Allen

(Physician or midwife)

Address Sandpoint Ida

Filed July 3 1926

Registrar.

Viola Allen
Deputy Registrar.

Constance L. L. L.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 6 1926 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. **53799**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 77
Primary Registration District No. 2155
(No. _____)

Local Registrar's No. _____

If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Infant Conyers

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 17, 1926

7 AGE Years Months Days 1 If LESS than day, hrs. or min. Stillbirth

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

10 NAME OF FATHER Vernon L. Conyers

11 BIRTHPLACE OF FATHER (city or town) Cascade, Colo
(State or country)

12 MAIDEN NAME OF MOTHER Mary Herrick

13 BIRTHPLACE OF MOTHER (city or town) Alpha, Idaho
(State or country)

14 Informant Vernon L. Conyers
(Address) Sandpoint, Idaho

15 Filled June 18, 1926 Viola Allen
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 17 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to 6-17, 1926.
that I last saw h_____ alive on _____, 19____.
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn. Instrumental delivery.

(duration) yrs. mos. ds.
CONTRIBUTORY Difficult Labor
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of 6-17-26

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. E. Allen, M. D.
6-17, 1926 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Pinecrest Cemetery Date of Burial June 18, 1926

20 Undertaker L. H. Moon Address Sandpoint Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

765-209-010-453
County of Bonneville
City of Idaho Falls

RECEIVED JUN 18 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

142091

No. Memorial Dist. Registration District No. 73 State File No. 214-2
Hospital St. Luke's Primary Registration District No. 171 Local Registrar's No. 171

FULL NAME OF CHILD

Baby Gonzales
(Certificate of no value without full name of child)

Sex of Child Female { Twin } and { Number in order of birth 1 } Legitimate? yes Date of birth May 9 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Jesui Gonzales
RESIDENCE Seegar Factory
COLOR Mexican AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Mexico
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Praxedad Delgado
RESIDENCE Seegar Factory
COLOR Mexican AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Mexico
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:55 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

John O. Melber
(Physician or midwife)

Address

Idaho Falls, Ida

Filed

May 14 1926 Weyfman

Registrar.

Registrar.

Pro of apas
of Court.
Aug 22 24

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

52221

State File No.

Local Registrar's No. *AF*

PLACE OF DEATH
County of *Bonneville*
City of *Idaho Falls*

Registration District No.

Primary Registration District No.

(No. *101 Hospital*)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Infant Jesus Gonzales*

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State).

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Mexican

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

May 5, 1926

7 AGE

Years

Months

Days

Born Dead

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Idaho Falls Ida

10 NAME OF FATHER

Jesus Gonzales

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mexico

12 MAIDEN NAME OF MOTHER

Trinidad Delgado

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mexico

14 Informant *Jesus Gonzales*
(Address)

15 Filled *May 7, 1926* *C. C. Hayes*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May
(Month)

5
(Day)

26
(Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH was as follows:

Still born from prolapse of a loop of the cord. Agave medical and surgical.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

No

Did an operation precede death? Date of *May 5, 1926*

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John O. McLeod* M.D.
Mms. 26 (Address) *Idaho Falls, Ida*

*State the DISEASE, INJURY, or CAUSE OF DEATH, and (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal *Lincoln Ida* Date of Burial *May 7, 1926*

20. Undertaker *C. C. Hayes* Address *Idaho Falls Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WHITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

318-224 070-814
PLACE OF BIRTH

RECEIVED JUL 6 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock
City of Idaho Falls

CERTIFICATE OF BIRTH

No. Memorial Registration District No. 73 State File No. 142115
Hospital L. D. S. Primary Registration District No. 215 Local Registrar's No. 272

FULL NAME OF CHILD

Baby Layson
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? 1 and { Number in order of birth 1 Legitimate? yes Date of birth June 24 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 70 Number of child of this mother now living, including present birth 9

FATHER
FULL NAME Henry C. Layson
RESIDENCE R7 Idaho Falls
COLOR white AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE Utah
OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Genevieve Hammer
RESIDENCE R7 Idaho Falls
COLOR white AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Kamsville Utah
OCCUPATION R. Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11 25 a 9 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

192

Registrar.

Registrar.

609

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JUL 6 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

555-18010-515
County of Sonneville
City of Idaho Falls, Idaho

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 73 State File No. 142132
Hospital _____ Primary Registration District No. 2ND Local Registrar's No. 24-9

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Male { Twin Triplet or other? } and { Number in order of birth } Legitimate? Yes Date of birth 5/16 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth 8 ✓ Number of child of this mother now living, including present birth 8 ✓

FATHER
FULL NAME Jos. A. Everett
RESIDENCE Idaho Falls, Idaho
COLOR White AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Hooper, Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Bessie May Van Eggs
RESIDENCE Idaho Falls, Idaho
COLOR White AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Morland Iowa
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at _____ M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
none, 1926

(Signature) G. C. Hollister
MD
(Physician or midwife)

Address Idaho Falls, Idaho
Filed 6/11 1926 L. J. ...
Registrar.

1
4
Unknown

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 2146
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phillip Everett

State File No. 52816
Local Registrar's No. 94

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word)

6. DATE OF BIRTH

May 16 1926
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
Yrs. Mos. ds. hrs. or min.?
✓ Yrs. ✓ Mos. ✓ ds. ✓ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None.

9. BIRTHPLACE

(State or Country) Idaho Falls.

10. NAME OF FATHER

James H. Everett

11. BIRTHPLACE OF FATHER

(State or Country) Blair Co. Utah.

12. MAIDEN NAME OF MOTHER

Bessie May Van Epps

13. BIRTHPLACE OF MOTHER

(State or Country) Moreland Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James H. Everett
P. R. 2.

15.

Filed

May 1719 26Wm. J. McHardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH

May 16 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19 26 to 5/16 19 26

that I last saw ~~him~~ alive on 19 26,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Hollister M. D.

19

(Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place ✓ yrs. ✓ mos. ✓ days. In the State ✓ yrs. ✓ mos. ✓ ds.

Where was disease contracted if not at place of death?

Former or usual residence ✓

RECEIVED JUN 18 1926

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill Cemetery May 16 19 26

20. UNDERTAKER

ADDRESS

D. J. McHardy 343 E. St.
Idaho Falls, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 6 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Shoshone Falls

No. 986913010986

St. Registration District No. 7

State File No. 142167

Hospital General

Primary Registration District No. 215A

Local Registrar's No. 224

FULL NAME OF CHILD Infant - Placenta

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate? yes

Date of
birth June 13 1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes? -

Number of child of this mother, including present birth ✓

Number of child of this mother now living, including present birth 4

FULL
NAME

FATHER

Joseph Placenta

RESIDENCE

Shoshone Falls Idaho

COLOR

White

AGE AT LAST

BIRTHDAY 32

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Truck driver

FULL
MAIDEN
NAME

MOTHER

Helen Placenta

RESIDENCE

Shoshone Falls Idaho

COLOR

White

AGE AT LAST

BIRTHDAY 28

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was Stillborn at 3 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 1926

(Signature) W. J. Placenta

(Physician or midwife)

Address Shoshone Falls Idaho

Filed 6/17 1926

Registrar.

Registrar.

6-7 mos
past available
Period

THE UNIVERSITY OF CHICAGO

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

CERTIFICATE OF DEATH

State File No. **53233**

PLACE OF DEATH

County of Bonnerville
City of Idaho Falls

Registration District No. 23

Primary Registration District No. 120

Local Registrar's No. 777

(No. Spencer Hospital)
 ed in a Hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Infant Richards.

(a) Residence. No. 1 St. 1

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
-------	-----------------	---

Male White Single
5a If married, widowed, or divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 2 1996

7 AGE Years Months Days If LESS than 1 day, 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer) .

(c) Name of employer

9 BIRTHPLACE (city or town) Shaw's Falls,
(State or country) N.Y.

10 NAME OF FATHER Joe Rhoads

11 BIRTHPLACE OF FATHER (city or town)
(State or country) 1 / # Idaho

12 MAIDEN NAME OF MOTHER *D. W. L. L.*

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Calif*

14 Informant. Joe F. Woods
(Address) 2114 N. 1st St. Ida

15 Filed 6/17, 1928 W. H. ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 6/13, 1926, to 6/13, 1926,
that I last saw h. _____ alive on _____, 19____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stemature 6-7 mo

CONTRIBUTORY (Secondary) *Acute leukemia* (duration) _____ yrs. _____ mos. _____ ds.

(duration) yrs. / mos. ds

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death?..... Date of

Was there an autopsy?

What test confirmed diagnosis?.....

(Signed) W. J. Remond M. D.
June 1st 1926 (Address) Idaho Falls, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal <i>Geon Ida</i>	Date of Burial <i>June 18 1924</i>
--	---------------------------------------

20. Undertaker	Address
E. C. Hayes	Shelton, Conn.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 12 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 142201

No. 231-226.012-235 St. Registration District No. 59 State File No.

Hospital Primary Registration District No. 2129 Local Registrar's No. 64

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other One and { Number in order of birth — Legitimate? yes Date of birth 5-26-1926 (Month) (Day) (Year)

What bactericidal solution was used in eyes? 10 cc. of 1% solution

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME FATHER McJ. Flash

RESIDENCE Moore Idav.

COLOR White AGE AT LAST BIRTHDAY 25 (Years)

BIRTHPLACE Sweden

OCCUPATION Farmer

FULL MAIDEN NAME MOTHER Beda Steele

RESIDENCE Moore Idav.

COLOR White AGE AT LAST BIRTHDAY 21 (Years)

BIRTHPLACE Vermont

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn 6:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. H. Parkin
(Physician or midwife)

Address Arco, Idaho

Filed May 27, 1926 J. B. Salt

Registrar.

Registrar.

PLACE OF BIRTH -

12



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V.-S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Bulte
City of Moore

Registration District No. 59
Primary Registration District No. 2129
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No name

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 53945

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

neither

(Write the word.)

6. DATE OF BIRTH.

May 27 1926
(Month) (Day) (Year)

7. AGE

Still born

If LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

None

9. BIRTHPLACE

(State or Country)

Moore, Idaho

10. NAME OF FATHER

Wm. Bladh

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Beda Steele

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. J. Bladh

(Address)

Moore, Idaho

15.

Filed

May 28, 1926J. C. Salt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 27 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
5-27 1926, to 5-27 1926,
that I last saw h. — alive on — 191 —

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. C. Salt M. D.19. (Address) Moore, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

RECEIVED JUN 12 1926

19. PLACE OF BURIAL OR REMOVAL

Moore, Idaho

DATE OF BURIAL

May 28, 1926

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
125-21014 RECEIVED JUN 30 1926
County of Conyon
City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 7 State File No. 142209
Hospital May Primary Registration District No. 1006 Local Registrar's No. 174
FULL NAME OF CHILD Helen Abel

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth June 21 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? To Sol. Silver 7.5

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Reed John Plumb
RESIDENCE Nampa
COLOR white AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Colorado
OCCUPATION Minister

MOTHER
FULL MAIDEN NAME Bessie Helen Cole
RESIDENCE Nampa
COLOR white AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Colorado
OCCUPATION Teacher

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at 6:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Registrar.

Registrar.

Nov

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1.

PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF

Father

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1926

June 28

Mrs. Zesby

Local Registrar

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19. to June 21 1926,

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Conventional death a week
or 10 days before delivery
Cause unknown

(Duration) yrs. mos. ds.
Contributory (Secondary) Nephritis of mother

(Signed) Geo. R. Porter M. D.
19 (Address)ampa, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerlain,ampa June 22 1926

20. UNDERTAKER

ADDRESS

Mrs. Minnie Talley,ampa

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 8 1926

PLACE OF BIRTH

249-124 023 249

County of Germ

City of Emmett

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

142384

No. _____ St. _____ Registration District No. 9 State File No. _____

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD No name

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth 6-24 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 13 Number of child of this mother now living, including present birth 10

FATHER
FULL NAME James Warren Smith
RESIDENCE Emmett
COLOR White AGE AT LAST BIRTHDAY 45 (Years)
BIRTHPLACE Virginia
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Bertha May Smith
RESIDENCE Emmett Ida
COLOR White AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Va
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:00 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) J. Reynolds
(Physician or midwife)

Address Emmett Ida

Filed 6-26 1926

Registrar.

Registrar.

MADE MUST BE TO BE
 IN THE CASE OF THE
 CHILD TO BE BORN
 BY THE MOTHER
 TO BE BORN
 IN THE CASE OF THE
 CHILD TO BE BORN
 BY THE MOTHER
 TO BE BORN
 IN THE CASE OF THE
 CHILD TO BE BORN
 BY THE MOTHER
 TO BE BORN

President

Register.

(The names added from a supplemental report
 above after review of the actual birth
 child is one that neither prescribes nor
 one should make the return. A stillborn
 child is one that the father has declared
 When there was no attending physician
 on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 11:00 AM on the date above stated.

(Physician or midwife)

Filed

192

Register

OCCUPATION

RESIDENCE

AGE AT BIRTH

SEX

NAME

FATHER

Known to the mother, including present and

What hospitalization was used in case of

CHILD

Twins

Other

DATE OF BIRTH

(To be completed only in case of stillborn child)

Weight

Length

Birth

Place

Time

Date

Year

Month

Day

CERTIFICATE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 STATE OF IDAHO

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M.

RECEIVED JUL 6 1926

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **53907**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of San

Registration District No. _____

City of EmmettPrimary Registration District No. 6

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still Barn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Infant
(Write the word.)

6. DATE OF BIRTH

June 24 1926
(Month) (Day) (Year)

7. AGE

Still born
Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country) Emmett Ida

10. NAME OF FATHER

James Warner Smith

11. BIRTHPLACE OF FATHER

(State or Country) Ida

12. MAIDEN NAME OF MOTHER

Bertha Pearl Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

6-25-1926

J. H. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 25 - 26 19____
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____ At birth 19____

that I last saw h. _____ alive on _____ 19____.

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Poecentis Previa Child
lost in delivery

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

M. D.

6/25/1926 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Emmett Ida

DATE OF BURIAL

6/25-1926

20. UNDERTAKER

Father

ADDRESS

Emmett

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 6 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

96428023 249
County of Idaho

City of Emmett Id

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 6 State File No. 142385

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD

No name

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ } and { Number in order of birth _____ } Legitimate? <u>yes</u>	Date of birth <u>June 18th 1926</u> (Month) (Day) (Year)
----------------------------	--	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth one

FATHER
FULL NAME Raymond Petis Modin
RESIDENCE Emmett Id
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Flossie Pearl Smith
RESIDENCE Same
COLOR W AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Indiana
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5³⁰ P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. H. Reynolds
Emmett Id
(Physician or midwife)

Address

Filed 6-19 1926

Registrar.

Registrar.

FORM V. S. No. 5-20-10-11

RECEIVED JUL 6 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1000

County of ZemPrimary Registration District No. 6File No. 52908City of Emmett ID (No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stell Barn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White Infant
(Write the word.)

6. DATE OF BIRTH

June 18 1926
(Month) (Day) (Year)

7. AGE

Stell BarnIF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Emmett ID

10. NAME OF FATHER

Raymond P. Modin

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Florence Pearl Smith

13. BIRTHPLACE OF MOTHER

(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Raymond P. Modin(Address) Emmett

15.

Filed 6-19- 1926Local Registrar J. H. Reynolds

MEDICAL CERTIFICATE OF DEATH

1896

16. DATE OF DEATH

Stell Barn 4-18-26
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth 19that I last saw him..... alive on..... 19

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stell Barn(Duration) Yrs. mos. ds.Contributory (Secondary) not known(Duration) yrs. mos. ds.(Signed) J. H. Reynolds M. D.6-19-26 (Address) Emmett ID

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett ID

DATE OF BURIAL

6-19 1926

20. UNDERTAKER

Father

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACED IN BIRTH JUL 6 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

142431

County of IdahoCity of GrangevilleNo. 195-208025-375 St.Registration District No. 103 State File No.

Hospital

Primary Registration District No. 2181 Local Registrar's No. 12

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>6</u> <u>8</u> <u>1926</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	---------------------------	---

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Frank H. Wieder
RESIDENCE Grangeville Idaho
COLOR White AGE AT LAST BIRTHDAY 38
(Years)
BIRTHPLACE Salesburg Mo.
OCCUPATION Warehouse helper

MOTHER
FULL MAIDEN NAME Eveline Crea
RESIDENCE Grangeville Idaho
COLOR White AGE AT LAST BIRTHDAY 32
(Years)
BIRTHPLACE Grangeville Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6 a.m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. Skirnick M.D.
(Physician or midwife)

Give names added from a supplemental report.

Address Grangeville, Idaho
Filed 7-1- 1926 B Chipman
Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

10

life after birth
breast or shows other evidence of
A stillborn child is one that neither
holder etc. should make this return
of miteled, and the other cases -
-When there was no attending physician

...interrogation & moral behavior among others

RECEIVED

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

On the date above stated I hereby certify that I attended the birth of this child.

(continued)

(CONTINUED TO 4-B101207)

100-443887-100

~~CONFIDENTIAL~~

OCUPATION

6154 HPLACR

COLOS

ЭНЦИКЛОПЕДИЯ

1007

RENTAL

Number of cells of this species, including ones

...that bacterial action was used in 1907.

(Refused Security to travel re view baseborn of T) [Signature] Blue

ENTER NAME OF OFFEROR

.....
 (Certificate of no value without full name of child)
 FULL NAME OF CHILD

to send this	order of	and in	light to	to send this
-----------------	-------------	-----------	-------------	-----------------

CERTIFICATE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

OHAGI TO STATE

SECRET

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

City of Jefferson
County of Rigby
213-216 026-753 St.

RECEIVED

CERTIFICATE OF BIRTH 142501

Registration District No. 98 State File No. _____Hospital _____ Primary Registration District No. 2176 Local Registrar's No. 125

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>J.</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>Yes</u>	Date of birth <u>5/16/1926</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 5

FULL NAME <u>Lee Bates</u>	FATHER
RESIDENCE <u>Rigby</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Nettie Peterson</u>	MOTHER
RESIDENCE <u>Rigby</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Ray H. Fisher

(Physician or midwife)

Address

Rigby

Filed

6/10/26

192

Ray H. Fisher

Registrar.

Registrar.

RECEIVED JUN 28 1926

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

Asperula procumbens



1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many..... hrs.

or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

RECEIVED

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

BUREAU OF VITAL

STATISTICS

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 53938-3

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Still Born. Premature Separation of Placenta.

(Duration)

Yrs.....

mos.....

ds.

Contributory
(Secondary)

(Duration)

Yrs.....

mos.....

ds.

(Signed)

M. D.

19.....

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days..... In the State..... yrs..... mos..... days.....

Where was disease contracted if not at place of death?

Former or usual residence

RECEIVED JUN 28 1926

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 10 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Butler

City of Bonanza

CERTIFICATE OF BIRTH

142557

No. 314-12028-155 St. Registration District No. State File No.

Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD Baby Cameron

(Certificate of no value without full name of child)

Sex of Child <u>M</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Y</u>	Date of birth <u>Apr 12</u> 192 <u>6</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Wesley Cameron</u>	<u>Rose Lake</u>	<u>Loris Jenkins</u>	<u>Sumner</u>
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Savannah Ga.</u>	OCCUPATION <u>laborer</u>	BIRTHPLACE <u>Bonanza Wash</u>	OCCUPATION <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1130 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. Schrader MD

(Physician or midwife)

Address Rose Lake Idaho

Filed July 1 1926 K J May

Registrar.

Registrar.

There was no attending physician at the time the victim was killed. The doctor who made the autopsy made the following statement:

RECEIVED JUL 10 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

53977

State File No.

Local Registrar's No. 12

PLACE OF DEATH

County of Kootenai
City of Rose LakeCERTIFICATE OF DEATH
Registration District No. 126
Primary Registration District No. 2304(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Rose Lake 2da St.(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) apr 12 26

7 AGE Years Months Days 1 day. LESS than hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rose Lake
(State or country) Idaho10 NAME OF FATHER Nestor Cameron11 BIRTHPLACE OF FATHER (city or town) Savannah B.C.
(State or country)12 MAIDEN NAME OF MOTHER Marie Jenkins13 BIRTHPLACE OF MOTHER (city or town) Wash
(State or country)14 Informant Nestor Cameron
(Address) Rose Lake 2da

15 Filled _____, 19____ Registrar

16 DATE OF DEATH April 12 26
(Month) (Day) (Year)17 April 12 1926 I HEREBY CERTIFY, That I attended deceased from
to April 12 1926

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted,
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) D. T. Schenckel M. Drapr. 12, 1926 (Address) Rose Lake 2da*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

19

20. Undertaker

Address

WHILE FILLING, WITH UNFOLDING INSTRUCTIONS, WITH UNFOLDING INSTRUCTIONS, WITH UNFOLDING INSTRUCTIONS. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 23 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

142568
S 9

County of Satah
City of Rendrick
No. 652104029344 St. Registration District No. 2147 State File No. 10
Hospital _____ Primary Registration District No. 67 Local Registrar's No. 10
FULL NAME OF CHILD Willard Weber

(Certificate of no value without full name of child)

Sex of Child M. Twin Triplet or other? ✓ and { Number in order of birth 1 } Legitimate? yes. Date of birth 4/4 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth 13 Number of child of this mother now living, including present birth 18

FATHER
FULL NAME Chas. Weber
RESIDENCE Rendrick P. 2
COLOR W. AGE AT LAST BIRTHDAY 37
(Years)
BIRTHPLACE Germany
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Elsie Cumstock
RESIDENCE Rendrick P. 2
COLOR W. AGE AT LAST BIRTHDAY 43
(Years)
BIRTHPLACE Mich
OCCUPATION H. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was born alive at Stillborn at 12:17 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1926

(Signature) P. G. Faust
Phys.
(Physician or midwife)

Address Leary
Filed 4/5 1926 P. G. Faust
Registrar. Registrar.

Registrar.

Placenta Praevia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

52784

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Salah*

City of *Rendrick P. 2*

If death occurs away from
usual residence, give facts
called for under special in-
formation.

(No. _____ St.)

2. FULL NAME

Willard Weber

State File No. *3*

Local Registrar's No. *35*

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

M. *W.* *Infant*
(Write the word)

6. DATE OF BIRTH

4-4-1926
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
Yrs. Mos. ds. min.?

0 Yrs. *0* Mos. *0* ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF
Father

Chas. Weber

11. BIRTHPLACE
OF FATHER

(State or Country)

Germany

12. MAIDEN NAME
OF MOTHER

Elsie Crumstock

13. BIRTHPLACE
OF MOTHER

(State or Country)

Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Weber

(Address)

Rendrick P. 2

15.

Filled

4-5

1926

Pl. F.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4-4-1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to *19*,
that I last saw him alive on *never* *19*,
and that death occurred on the date stated above, at *12:17 P.*

The CAUSE OF DEATH* was as follows:

Stillborn
Placenta previa

(Duration) *✓* yrs. *✓* mos. *✓* ds.

Contributory
(Secondary)

(Duration) *✓* yrs. *✓* mos. *✓* ds.

(Signed)

4/5-1926

Pl. F. M. D.

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Alwood Cem

DATE OF BURIAL

4/5-1926

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

154 712-029-394
PLACE OF BIRTH RECEIVED JUL 9 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

142575

County of Latoh
City of Moscow

No. _____ St. _____
Hospital Inland

Registration District No. 61

File No. _____

Primary Registration District No. 1011

Registered No. 62

FULL NAME OF CHILD

Stillbirth

(Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twins or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>June 12</u> 192 <u>6</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth None

FATHER
FULL NAME Joseph O. Anderson
RESIDENCE Genesee Idaho

MOTHER
FULL MAIDEN NAME Olivia Lideyan
RESIDENCE Genesee Ida.

COLOR White AGE AT LAST BIRTHDAY 39 (Years)

COLOR White AGE AT LAST BIRTHDAY 31 (Years)

BIRTHPLACE Minnesota

BIRTHPLACE S. D. Ark.

OCCUPATION Farmer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. J. Curtis
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Moscow Idaho
Filed 7-7-1926 M. H. Carothers
Registrar.

2

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 4 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

City of Leadore

No. 993127030-753

St. Registration District No. 42

State File No. 142593

Hospital

Primary Registration District No. 2153 Local Registrar's No. 56

FULL NAME OF CHILD X

(Certificate of no value without full name of child)

Sex of
Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

Jan 27

1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FULL
NAME

FATHER

Wm. Hill

RESIDENCE

Leadore, Idaho

COLOR

White

AGE AT LAST

BIRTHDAY

29
(Years)

BIRTHPLACE

Wellington Utah

OCCUPATION

Farming

FULL
MAIDEN
NAME

MOTHER

Dora Peterson

RESIDENCE

Leadore

COLOR

White

AGE AT LAST

BIRTHDAY

28
(Years)

BIRTHPLACE

Driggs, Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at Leadore A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

Dr. B. B. Peterson

(Physician or midwife)

Address

Leadore, Idaho

Filed

June 20 1926

Ethel Peterson

Registrar.

7ms

Orzechowiec

Station Data
by E. J. ...

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V, S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Benewah
City of Leadore

Registration District No. 46
Primary Registration District No. 2153
(No. St.)

State File No. 53997
Local Registrar's No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(Infant) Hill
Stiefborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Infant
(Write the word)

6. DATE OF BIRTH

Jan. 1 1926
(Month) (Day) (Year)

7. AGE

Stief Born IF LESS than 1 day how many
.....hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Leadore, Idaho

10. NAME OF FATHER

Wm. Hill

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Flora Peterson

13. BIRTHPLACE OF MOTHER

(State or Country) Brigg, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Flora Peterson
(Address) Leadore, Ida

15.

Filed June 20 1926 Ethel Peterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 1 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1926 to 19 1926,
that I last saw him alive on 19 1926,
and that death occurred on the date stated above, at a.m.

The CAUSE OF DEATH* was as follows:

Immature birth
(Dead at birth. No known cause). Dead of Gestation 7 mos.
(Duration) 7 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. B. Hill M. D.

1926 (Address) Leadore, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Junction Cemetery Jan 2 1926

20. UNDERTAKER

ADDRESS Leadore, Ida

RECEIVED JUN 24 1926

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH 284 115032-284
County of Lincoln
City of Dietrich
No. _____ St. Registration District No. 16 State File No. 142607
Hospital no Primary Registration District No. 2016 Local Registrar's No. 11
FULL NAME OF CHILD Thomas Shurtz
(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>1</u>	and {	Number in order of birth <u>1</u>	Legiti- mate? <u>yes</u>	Date of birth <u>May 15</u> 192 <u>6</u> (Month) (Day) (Year)
--------------------------	---------------------------------------	-------	---	-----------------------------	---

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth <u>7</u>		Number of child of this mother now living, including present birth <u>5</u>	
FULL NAME <u>Mrs. B. Shurtz</u>	FATHER	FULL MAIDEN NAME <u>Josephine Shurtz</u>	MOTHER
RESIDENCE <u>Dietrich Idaho</u>		RESIDENCE <u>Sevier County Utah</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)	COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Sevier County Utah</u>		BIRTHPLACE <u>Sevier County Utah</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Boy alive Stillborn at 12:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

W. H. Baughman

(Physician or midwife)

Address

Thornton, Idaho

Filed

May 17 1926

Registrar.

Registrar.

Examinatory & answering
+ answering

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 76County of LinsleyPrimary Registration District No. 2016City of Ortich

(No. _____)

St. _____

File No. 54008

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Shurtz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)6. DATE OF BIRTH May 15 - 1926

(Month)

(Day) 1

(Year)

7. AGE 36

Yrs.

Mos.

ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

none
Still Born

9. BIRTHPLACE

(State or Country)

Ortich-gaah10. NAME OF FATHER Geo Shurtz

11. BIRTHPLACE OF FATHER

(State or Country)

Utah12. MAIDEN NAME OF MOTHER Josephine Shurtz

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Shurtz(Address) Ortich-gaah15. May 17 1926

Filed

Local Registrar J. J. J. J.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 15 1926

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15th 1926, to May 15th 1926 that I last saw him alive on May 15th 1926 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Baugh M. D.5-15-1926 (Address) Shoshone Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

RECEIVED JUN 1 1 1926

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL ShoshoneDATE OF BURIAL 5-16 192620. UNDERTAKER O. J. BrennanADDRESS Shoshone

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 9 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WORKS
BUREAU OF VITAL STATISTICS

S

County of Madison

City of Blaine

CERTIFICATE OF BIRTH

No. 236121033-234 St.

Registration District No. 100

State File No.

142648

Hospital

Primary Registration District No. 2178

Local Registrar's No. 1463

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

May 21 1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes? 2

Number of child of this mother, including present birth 7

Number of child of this mother now living, including present birth 5

FULL
NAME

FATHER

Robert Blaser

RESIDENCE

Reynolds P#3

COLOR

W

AGE AT LAST
BIRTHDAY

25
(Years)

BIRTHPLACE

Ida

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Mary Steele

RESIDENCE

Reynolds P#3

COLOR

W

AGE AT LAST
BIRTHDAY

25
(Years)

BIRTHPLACE

Ida

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {born alive} at 2:50 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

7/4 1926

Registrar.

Registrar.



601

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 7 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Minidoka

City of Minidoka

No. 967125034-363 St.

Registration District No. 14

State File No. 142672

Hospital

Primary Registration District No. 2015 Local Registrar's No. 79

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of
Child

Male

Twin
~~Triplet~~
or other?

}

and { Number
in order
of birth

2

Legiti-
mate?

yes

Date of
birth

June 25 1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Neo Silver 15%

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

1

FULL
NAME

FATHER

John Rogalsky

RESIDENCE

Minidoka

COLOR

White

AGE AT LAST

BIRTHDAY

29
(Years)

BIRTHPLACE

Russia

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Monta Christiana Collins

RESIDENCE

Minidoka

COLOR

White

AGE AT LAST

BIRTHDAY

14
(Years)

BIRTHPLACE

Missouri

OCCUPATION

Prof.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 10 30 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

E. H. Ehmore

(Physician or midwife)

Address

Boise

Filed

7-1

1926

Registrar.

Registrar.

2

CERTIFICATE OF BIRTH

Registration District No. _____

Primary Registration District No. _____

(Certificate of no return without full name of child)

NAME OF CHILD

Sex of Child

Twin

and

Number

(To be answered only in case of twins)

Legality

Birth

(Date)

What declarable relation was used to register

Number of child of this mother, including present birth

Number of child of this mother, including present birth

MOTHER

FATHER

FULL NAME

FULL NAME

RESIDENCE

RESIDENCE

COLOR

COLOR

AGE AT LAST BIRTHDAY

AGE AT LAST BIRTHDAY

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

born on the date above stated

When there was no attending physician or midwife, then the household or family doctor, or other person, who attended the birth of this child, should state this person's name and address, and that the child is one that mother practices.

Shows other evidence of the mother's name as used from a supplemental report.

Address

Place

(Signature of midwife)

(Signature)

TO BE FILLED IN BY THE REGISTRAR

263-109 035-555

RECEIVED JUL 12 1909

Form V. S. No. 11-C--25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

142699

County of Ney

City of Spalding

Registration District No. 128

File No.

No. _____ St. _____

Primary Registration District No. _____

Registered No. _____

Hospital _____

FULL NAME OF CHILD

(Unnamed)

Bolem

Sex of Child Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth
(To be answered only in event of plural births)

Legiti
mate?

yes.

Date of Birth

June 9 1926
(Month) (Day) (Year)

FULL NAME

Louie Bolem

FATHER

FULL MAIDEN NAME

Maud Neel

MOTHER

RESIDENCE

Spalding Idaho.

RESIDENCE

Spalding Idaho.

COLOR

White

AGE AT LAST BIRTHDAY

31

(Years)

COLOR

White

AGE AT LAST BIRTHDAY

35

(Years)

BIRTHPLACE

Indiana

BIRTHPLACE

Virginia

OCCUPATION

Laborer

OCCUPATION

Housewife

Number of child of this mother, including present birth 9

Number of children of this mother now living, including present birth 7

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ on the date above stated.

Still Born

9:00 P. M.

(Born alive or stillborn)

(Signature)

Geo. O. Keen M.D.
Physician, Lapwai Idaho.
(Physician or midwife)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

19

Address

Filed June 1926

George Guinn
Registrar

[illegible]

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 10 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

154-22040-355

County of Shoshone

City of Wallace

CERTIFICATE OF BIRTH

142758

No. _____ St. Registration District No. 72 State File No. _____

Hospital Providence Primary Registration District No. 1011 Local Registrar's No. 9

FULL NAME OF CHILD Shirley Mae Anderson

(Certificate of no value without full name of child)

Sex of Child <u>7</u>	Twin Triplet or other? <u>1</u> and { Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>5-21-1926</u> (Month) (Day) (Year)
-----------------------	---	------------------------	--

What bactericidal solution was used in eyes? Oxydol

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER	MOTHER
FULL NAME <u>Joseph D Anderson</u>	FULL MAIDEN NAME <u>Ollie Lee</u>
RESIDENCE <u>Wallace, Ida</u>	RESIDENCE <u>Wallace</u>
COLOR <u>W</u>	COLOR <u>W</u>
AGE AT LAST BIRTHDAY <u>29</u> (Years)	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Arkansas</u>	BIRTHPLACE <u>Diamond, Wash</u>
OCCUPATION <u>Butcher</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { born alive } Stillborn at 1:24 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]
(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed June 8 1926

Registrar.

Registrar.

JAN 8 1943

day

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

253 105042-271
PLACE OF BIRTH

JUN 12 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls
City of Twin Falls
No. 752-2nd Ave East

CERTIFICATE OF BIRTH

Registration District No. 37 State File No. 142790

Hospital _____ Primary Registration District No. 1085 Local Registrar's No. _____

FULL NAME OF CHILD Kelly
(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>1</u> and { Number in order of birth _____ }	Legitimate? <u>yo.</u>	Date of birth <u>April 5</u> 192 <u>6</u> (Month) (Day) (Year)
--------------------------	--	------------------------	---

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Earl Franklin Kelly
RESIDENCE Twin Falls, Ida
COLOR white AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE Ireland
OCCUPATION blacksmith

MOTHER
FULL MAIDEN NAME Virian Spante
RESIDENCE Twin Falls, Ida
COLOR white AGE AT LAST BIRTHDAY 17 (Years)
BIRTHPLACE Wash
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn { Non-viable } at 79 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1926

(Signature) Hercland
Physician
(Physician or midwife)

Address Twin Falls, Ida

Filed June 1926 John Hargill
Registrar.

1. I hereby certify that I attended the birth of this child, who was born on the date above stated.
 2. When there was no attending physician or midwife, then the father, husband or other male person, a relative, or friend of the mother, or the mother herself, is one who is considered as the attending physician.
 3. The number and date of registration report.

I hereby certify that I attended the birth of this child, who was born on the date above stated.
 When there was no attending physician or midwife, then the father, husband or other male person, a relative, or friend of the mother, or the mother herself, is one who is considered as the attending physician.
 The number and date of registration report.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

OCCUPATION _____
 BIRTHPLACE _____
 COLOR _____
 AGE AT LAST BIRTHDAY (Month) _____
 NAME _____
 FATHER _____
 MOTHER _____
 Number of children of this mother, including present birth _____
 Number of children of this mother now living, including present birth _____
 What investigation or treatment was used in event of abnormal event of birth? _____
 Sex of child _____
 Date of birth (Month) _____ (Day) _____ (Year) _____
 Date of registration _____
 Primary Registration District No. _____
 State _____
 Local Registrar No. _____
 COUNTY BOARD OF HEALTH _____
 1920

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

APR 12

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County of Franklin Registration District No. 37

City of Idaho Falls Primary Registration District No. 1085

(No. 752-9 on 8-27)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Leobard Kelly

(a) Residence. No. 659 2 Street St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Infant

16 DATE OF DEATH April 5 19 26
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from April 5 19 26 to April 5 19 26
that I last saw him dead on April 5 19 26
and that death occurred, on the date stated above, at _____ m.

6 DATE OF BIRTH (month, day and year)

The CAUSE OF DEATH* was as follows:
Stillborn

7 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.
0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) prolonged labor
(duration) _____ yrs. _____ mos. _____ ds.

9 BIRTHPLACE (city or town) Idaho Falls Idaho
(State or country)

18 Where was disease contracted
If not at place of death?

10 NAME OF FATHER Sailor Kelly

Did an operation precede death? no Date of _____

Was there an autopsy? no

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

What test confirmed diagnosis?

12 MAIDEN NAME OF MOTHER Marion Sparks

(Signed) Howe M. D.
April 5 19 26 (Address) Idaho Falls Idaho

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14 Informant Sailor Kelly
(Address)

19 Place of Burial, Cremation, or Removal Idaho Falls Date of Burial April 6 19 26

15 Filed Apr 19 26 John L. Dougherty
Registrar

20 Undertaker E. E. Hewitt Address Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

PLACE OF BIRTH

RECEIVED JUN 12 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

142795

County of Twin FallsCity of Twin FallsNo. 799107042-365St. Registration District No. 37

State File No.

Hospital Twin Falls Cont.Primary Registration District No. 2085

Local Registrar's No.

FULL NAME OF CHILD

John Griffin

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?

} and {

Number
in order
of birth

(To be answered only in event of plural births)

Legitimate?

yes

Date of birth

May 71926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth

6

Number of child of this mother now living, including present birth

3FULL
NAME

FATHER

Enoch A. Griffin

RESIDENCE

R. 2 Twin Falls.

COLOR

whiteAGE AT LAST
BIRTHDAY49
(Years)

BIRTHPLACE

Laplata Missouri

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Julia Conarty.

RESIDENCE

R. 2 Twin Falls

COLOR

whiteAGE AT LAST
BIRTHDAY45
(Years)

BIRTHPLACE

Morton Kansas

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 1926

Registrar.

(Signature)

D. H. Alexander
(Physician or midwife)

Address

Twin Falls Ida

Filed

June 1926 John H. Houghlin
Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

UNITED STATES OF AMERICA

SECRET

Federal Investigation Division

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

[illegible]

15:00

Page 1

100-443887-100

1. NAME
 2. DATE
 3. TIME
 4. LOCATION
 5. REMARKS
 6. SIGNATURE
 7. INITIALS
 8. MOBILE
 9. HOME
 10. WORK
 11. OTHER
 12. REMARKS
 13. SIGNATURE
 14. INITIALS
 15. MOBILE
 16. HOME
 17. WORK
 18. OTHER
 19. REMARKS
 20. SIGNATURE
 21. INITIALS
 22. MOBILE
 23. HOME
 24. WORK
 25. OTHER
 26. REMARKS
 27. SIGNATURE
 28. INITIALS
 29. MOBILE
 30. HOME
 31. WORK
 32. OTHER
 33. REMARKS
 34. SIGNATURE
 35. INITIALS
 36. MOBILE
 37. HOME
 38. WORK
 39. OTHER
 40. REMARKS
 41. SIGNATURE
 42. INITIALS
 43. MOBILE
 44. HOME
 45. WORK
 46. OTHER
 47. REMARKS
 48. SIGNATURE
 49. INITIALS
 50. MOBILE
 51. HOME
 52. WORK
 53. OTHER
 54. REMARKS
 55. SIGNATURE
 56. INITIALS
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 59. WORK
 60. OTHER
 61. REMARKS
 62. SIGNATURE
 63. INITIALS
 64. MOBILE
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 67. OTHER
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 71. MOBILE
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 73. WORK
 74. OTHER
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 237. SIGNATURE
 238. INITIALS
 239. MOBILE
 240. HOME
 241. WORK
 242. OTHER
 243. REMARKS
 244. SIGNATURE
 245. INITIALS
 246. MOBILE
 247. HOME
 248. WORK
 249. OTHER
 250. <

1944

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-14-2010 BY 60322 UCBAW

(Page 7)

14-00000

STATE OF ATTENDING PHYSICIAN OR MIDWIFE.

30

1

(91044810)

100-11112
100-11112

17-00000

0-17-68

SECRET

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 53663

Local Registrar's No. _____

PLACE OF DEATH RECEIVED

CERTIFICATE OF DEATH

County of Juniper MAY 18 Registration District No. 37

City of Juniper BUREAU OF VITAL STATISTICS Registration District No. 2085

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Griffin

(a) Residence. No. Rural Route 2 St. _____

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) May 6 1926

7 AGE Years 0 Months 0 Days 0 1 If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Juniper Falls Idaho

10 NAME OF FATHER Ericha Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) mo.

12 MAIDEN NAME OF MOTHER Julia Conarty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kansas

14 Informant E. A. Griffin (Address) Juniper Falls,

15 Filled May 1926 John Houghlin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6 1926 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1926, to May 6, 1926 that I last saw him alive on Stillborn, 1926 and that death occurred, on the date stated above, at 11 30 p. The CAUSE OF DEATH* was as follows:

Still born at 7 1/2 months

(duration) yrs. mos. ds. CONTRIBUTORY Desere Albuminuria (Secondary) 8 pregnancy in the mother, 3mo. (duration) yrs. mos. ds.

18 Where was disease contracted? ✓ If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. H. Alexander, M. D.

May 7, 1926 (Address) Juniper Falls, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Juniper Falls, Cemetery Date of Burial May 10 1926

20. Undertaker Paul Beer Address Juniper Falls,

A stillbirth must be registered both as a birth and a death. -The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

RECEIVED JUL 9 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

142837

County of J. F.City of BuhlNo. 366-21042-462 St.Registration District No. 39

State File No.

Hospital

Primary Registration District No. 2087

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

FemaleTwin
Triplet
or other?

}

and {

Number
in order
of birthLegiti-
mate?YesDate of
birth5-11-1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Argyrol

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

5FULL
NAME

FATHER

Lyman L. Cowles

RESIDENCE

Buhl

COLOR

whit.

AGE AT LAST

BIRTHDAY

61

(Years)

BIRTHPLACE

Mich.

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Minnie Moss

RESIDENCE

Buhl

COLOR

whit.

AGE AT LAST

BIRTHDAY

46

(Years)

BIRTHPLACE

W. Va.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10:30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Dr. Geo. Jennings
Buhl

(Physician or midwife)

Address

Filed JUN 3 1926

Registrar.

J. H. Murpley
Registrar.WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

Good strong relation
strong weak before
with

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 39
 County of Bull Primary Registration District No. 2087
 City of Bull (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Coles

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 53684
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

May 11 1926
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. da.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bull

10. NAME OF FATHER

LM Coles

11. BIRTHPLACE OF FATHER

(State or Country) Mich

12. MAIDEN NAME OF MOTHER

Minnie Moss

13. BIRTHPLACE OF MOTHER

(State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) LM Coles

(Address) Bull Id

15.

Filed 5-11 1926

J. H. Warpley
 Local Registrar

16. DATE OF DEATH

5-11-26
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-11-1926, to 5-11-1926, that I last saw him alive on 5-11-1926, and that death occurred on the date stated above, at 11 A.M. The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) No. Jennings

5-12-1926 (Address) Bull Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

RECEIVED JUN 4 - 1926

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

266-229 001 915
PLACE RECEIVED JUL 31 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 142979

County of Ada

City of Meridian

No. R7D1 St. Registration District No. State File No.

Hospital Primary Registration District No. Local Registrar's No. 88

FULL NAME OF CHILD Baby Bowers

(Certificate of no value without full name of child)

Sex of Child <u>♀</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>6 29 1926</u> (Month) (Day) (Year)
-----------------------	---	--------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? Silver Nitrate 1%

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME Edgar C. Bowers
RESIDENCE Meridian, Idaho R1
COLOR white AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE Alabama
OCCUPATION farmer

MOTHER
FULL MAIDEN NAME Russie J. Rae
RESIDENCE Meridian, Idaho R1
COLOR white AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Idaho
OCCUPATION at home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn Yat 7 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. T. Muf

(Physician or midwife)

Address Meridian, Idaho

Filed 7/2 1926 H. T. Muf Registrar.

Registrar.

CERTIFICATE OF BIRTH

County of _____
City of _____
No. _____
Registration District No. _____
Local Registrar's No. _____

NAME OF CHILD

(Certificate of no value without full name of child)

Sex of child _____
Date of birth _____
Time of birth _____
Place of birth _____
(To be answered in case of hospital birth)

What hospital or institution was used in case of hospital birth?

Name of child's father, including present name, if different from name at birth, and name of child's mother, including present name, if different from name at birth.

FATHER	MOTHER
NAME	NAME
RESIDENCE	RESIDENCE

COLOR	COLOR
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

When there was no attending physician or midwife then the father, grandfather or other person who was present at the birth should make this return. A stillborn child is one that neither shows nor shows other evidence of life after birth. Give names signed from a supplemental report.

Address _____
Signed _____
(Physician or midwife)

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A LEGAL DOCUMENT. RECORD N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 31 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

54120

State File No.

PLACE OF DEATH

County of Ada

Registration District No.

City of Meridian

Primary Registration District No. 11

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Bowers

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX F. 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) —

16 DATE OF DEATH 6 29 1926
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 6/29 I HEREBY CERTIFY, That I attended deceased from 6/29 1926, to 6/29 1926

6 DATE OF BIRTH (month, day and year) 6/29-26

that I last saw h. alive on Stillborn, 19 —

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

8 OCCUPATION OF DECEASED

Stillbirth, that caused by fall.
(duration) yrs. mos. ds.

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

9 BIRTHPLACE (city or town) Meridian
(State or country) Idaho-USA.

18 Where was disease contracted
If not at place of death?

10 NAME OF FATHER Edgar A. Bowers

Did an operation precede death? Date of

Was there an autopsy?

11 BIRTHPLACE OF FATHER (city or town) Alabama
(State or country)

What test confirmed diagnosis?

(Signed) W. F. Neal, M. D.

12 MAIDEN NAME OF MOTHER Gussie J. Rae

19 (Address)

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

14 Informant Edgar A. Bowers
(Address) Meridian Idaho

19 Place of Burial, Cremation, or Removal Home ranch Date of Burial 6/30 1926

15 Filled 6/30 1926 W. F. Neal
Registrar

20. Undertaker none Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE RECEIVED AUG 6 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

415-207903-256

County of Bannock

City of Bancroft

No. _____ St. _____

Hospital _____

Registration District No. 84

Primary Registration District No. 2161

File No. 142989

Registered No. 257

FULL NAME OF CHILD

Baby Davis

(Certificate of no value without full name of child.)

Sex of Child

Female

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

7-7-
(Month) (Day)

1926
(Year)

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 1

Number of child of this mother now living, including present birth... 1

FULL
NAME

FATHER

Harry Davis

FULL
MAIDEN
NAME

MOTHER

Effie Snow

RESIDENCE

Pendleton Oregon

RESIDENCE

Pendleton Oregon

COLOR

White

AGE AT LAST
BIRTHDAY

24
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

16
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Utah

OCCUPATION

Day Labourer

OCCUPATION

Nothing

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____
on the date above stated.

(Born alive or stillborn)

M.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

E. G. Fitz

(Physician or midwife)

Give names added from a supplemental report.

Address

Bancroft Idaho

Filed

7-7-1926

Mrs. E. G. Fitz

Registrar.

Registrar.

Unkennbar

RECEIVED AUG 6 1926

FORM V. S. No. 5-25 N. 1-10

RECEIVED AUG 6 1926

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 54125
Registered No. 51

1. PLACE OF DEATH
County of Bannock
City of Bancroft

Registration District No. 84
Primary Registration District No. 2161
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baty Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 1890

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH July - 7 - 1926
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day how many _____ hrs. or _____ min. ?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Harry Davis

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Effie Snow

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Effie Snow
(Address) Pendleton Oregon

15. Filed 7-7-1926 Mrs. J. W. Felt
Local Registrar

16. DATE OF DEATH July - 7 - 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____, that I last saw h. _____ alive on _____ 19____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Still born. Premature Cause unknown.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) E. A. Felt M. D.

7/7 1926 (Address) Bancroft Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Bancroft-Ida DATE OF BURIAL 7/7-1926

20. UNDERTAKER Had none ADDRESS _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for,
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED AUG 6 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock
City of Lava Hot Spring
No. 191716.003.893 St. Registration District No. 84 State File No. 142992
Hospital Municipal Primary Registration District No. 2161 Local Registrar's No. 239
FULL NAME OF CHILD Baby Arave

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and { Number in order of birth Legitimate? Yes Date of birth July 16 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Daniel Willis Arave
RESIDENCE Los Angeles Calif
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Ogden Utah
OCCUPATION Coach

MOTHER
FULL MAIDEN NAME Amanda Mary Hill
RESIDENCE Los Angeles Calif
COLOR White AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Freemant Co - Wyo
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 A.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Dr. G. P. Rich
Physician
(Physician or midwife)

Address Lava Hot Spring

Filed 7-17-1926 Mrs. E. J. Feb
Registrar.

Registrar.

5 ms
~~to~~ Kemia pregnancy

RECEIVED AUG 6 1926
 1. PLACE OF DEATH
 County of Bannock
 City of Lava Hot Springs
 Registration District No. 84
 Primary Registration District No. 2161
 No. _____ St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No name

54127-

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 53Registered No. 53

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

July 16 - 1926
 (Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day
 how many _____ yrs.
 or _____ mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Lava Hot Springs Idaho

10. NAME OF FATHER

Daniel Willis Arave

11. BIRTHPLACE OF FATHER

(State or Country)

 Ogden - Utah

12. MAIDEN NAME OF MOTHER

Amanda Mary Hill

13. BIRTHPLACE OF MOTHER

(State or Country)

Freemont Co. Wyo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. W. Arave

(Address)

Lava Hot Springs

15.

Filed

July - 17 - 1926 Mrs G. G. Fitz
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 16 1926
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1926 to July 16 1926 that I last saw him alive on 19 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Stillbirth - due to
Toxemia of pregnancy
 (Duration) Yrs. mos. ds.
 Contributory (Secondary) About 5 months
 (Duration) Yrs. mos. ds.
 (Signed) Dr. C. F. Rich M. D.
7-16-1926 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lava Hot Spgs.

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of *Beau Lake*

City of *Paris*

No. *335 108 004 753* St.

Hospital

Registration District No. *53*

State File No. *343*

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

Male

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

July 8

1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth *1*

Number of child of this mother now living, including present birth *0*

FULL
NAME

FATHER

Seymour G. Sleight

RESIDENCE

Paris Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

23

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Merchant

FULL
MAIDEN
NAME

MOTHER

Orletta Annetta Peterson

RESIDENCE

Paris Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

19

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Stillborn* at *3.20 A. M.*
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

O. O. Moore M.D.

Paris Idaho

(Physician or midwife)

Address

Filed

7-1 1926

Mary L. Williams

Registrar.

Registrar.

THIS IS A CERTIFICATE OF BIRTH FOR THE CHILD OF THE MOTHER AND FATHER WHOSE NAMES ARE GIVEN HEREIN. IT IS TO BE USED FOR THE PURPOSES OF IDENTIFICATION AND RECORD-KEEPING. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE KEPT IN A SAFE PLACE AND NOT TO BE LOST OR DESTROYED. IT IS TO BE USED AS EVIDENCE OF THE CHILD'S BIRTH AND AS A RECORD OF THE CHILD'S PARENTS.

City of _____ No. _____ Hospital _____		Primary Registration District No. _____ Local Registration No. _____	
FULL NAME OF CHILD _____			
(Certificate of no value without full name of child)			
Sex of Child _____ (To be returned only in case of twins)	Date of Birth _____ (Month) (Day) (Year)	Place of Birth _____ (City) (State) (Country)	Occupation _____
FATHER NAME _____ FULL NAME _____ RESIDENCE _____ AGE AT LAST BIRTHDAY _____ COLOR _____ BIRTHPLACE _____ OCCUPATION _____		MOTHER NAME _____ FULL NAME _____ RESIDENCE _____ AGE AT LAST BIRTHDAY _____ COLOR _____ BIRTHPLACE _____ OCCUPATION _____	
Number of child of this mother, including present birth _____		Number of child of this mother now living including present birth _____	
What supplemental solution was used in case? _____			
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE I hereby certify that I attended the birth of this child, who was _____ at _____ (Signature) _____ (Physician or midwife) Date _____			
The names added from a supplemental report _____ child is one that neither parent nor _____ et al. should make this return. A stillborn _____ or midwife. Then the father, householder _____ on the case above stated. _____ When there was no attending physician _____			

Filed _____
 A49122

Registrar

Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF RECEIVED AUG 6

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

437 206 006 947
County of Singham
City of Sterling

CERTIFICATE OF BIRTH

No. St. Registration District No. 116 State File 143023
Hospital Primary Registration District No. 2195 Local Registrar's No. 994

FULL NAME OF CHILD Wilma Charlotte McGahey
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u> and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>July 6</u> 192 <u>6</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>William Charles McGahey</u>	FULL MAIDEN NAME	<u>Nancy Rupe</u>
RESIDENCE	<u>Deceased</u>	RESIDENCE	<u>Sterling Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>20</u> (Years)	AGE AT LAST BIRTHDAY	<u>16</u> (Years)
BIRTHPLACE	<u>Oklahoma</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u> </u>	OCCUPATION	<u>W. W. G. E.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 8:45 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) M. C. MacKinnon M.D.

(Physician or midwife)

Address Aberdeen Idaho

Filed 7/10 192 6 M. C. MacKinnon

Registrar.

Registrar.

27 May

Hydrocephalus (lang)

FORM V. S. No. 5-1-11 RECEIVED AUG 6

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of StirlingRegistration District No. 116Primary Registration District No. 2153-File No. 54153Registered No. 1841

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wilma Charlotte McRae

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale white single
(Write the word.)

6. DATE OF BIRTH

July 6 1926
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.
IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Oklahoma

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nancy Rupe(Address) StirlingFiled July 6 1926 M. C. Matkinson
19. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 6 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw h. — alive on 19and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Still born -
Hydrocephalus (Large)(Duration) — Yrs. — mos. 28 ds.
Contributory Premature Birth
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) M. C. Matkinson M. D.19. (Address) Alameda Idaho

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Springfield Idaho Aug 10 1926

20. UNDERTAKER

ADDRESS

Friends

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACED **RECEIVED** AUG 6 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Brigham
City of Sterling
No. 239122-006423 St. Registration District No. 116 State File No. 143032
Hospital _____ Primary Registration District No. 2193 Local Registrar's No. _____
FULL NAME OF CHILD Still born Stroschein

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>-</u>	and { Number in order of birth <u>-</u>	Legiti- mate? <u>yes</u>	Date of birth <u>July 22 1926</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL MAIDEN NAME Earl H Stroschein
RESIDENCE Sterling Ida
COLOR white AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Wisconsin
OCCUPATION farmer

MOTHER
FULL MAIDEN NAME Kva Gertrude Miller
RESIDENCE Sterling Ida
COLOR white AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Missouri
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 4 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. C. Matkinson M.D.
Physician
(Physician or midwife)

Address Overdeen Ida

Filed July 31 1926 McInatun

Registrar.

Registrar.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 12-12-2001 BY 60322 UCBAW

CERTIFICATE OF BIRTH

County of Alameda
City of San Francisco
No. 123456789
Primary Registration District No. 1234
Local Registration District No. 5678

NAME OF CHILD

Full name of child (to be entered only in event of plural births)
First name John Middle name David Last name Smith
Sex of child Male
Date of birth Jan 15 1923
Place of birth San Francisco, Cal.

What hospital or institution was used in birth?

NAME	RESIDENCE	COLOR	BIRTHPLACE	OCCUPATION
FATHER Full name <u>John D. Smith</u>	<u>1234 Main St., San Francisco</u>	<u>White</u>	<u>San Francisco, Cal.</u>	<u>Engineer</u>
MOTHER Full name <u>Mary E. Smith</u>	<u>1234 Main St., San Francisco</u>	<u>White</u>	<u>San Francisco, Cal.</u>	<u>Homemaker</u>

Number of child of this mother, including present birth 1
Number of child of this mother, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive
on the date above stated.
When there was no attending physician or midwife, then the father, householder, etc., should make this report. A statement that is one that neither brother nor shows other evidence of the birth.
Give names added from a supplemental report.
Signature of Physician or Midwife Dr. J. H. Smith
Address 1234 Main St., San Francisco
Filed Jan 15 1923
Registrar J. H. Smith

RECEIVED AUG 6 1926

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Arden

Registration District No. 116
Primary Registration District No. 2185
(No. _____ St.)

File No. 54151
Registered No. 1926

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still born Stroschein

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH July 22 26
(Month) (Day) (Year)

7. AGE _____
Yrs. Mos. ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Earl Stroschein

11. BIRTHPLACE OF FATHER Wisconsin
(State or Country)

12. MAIDEN NAME OF MOTHER Una Gertrude Miller

13. BIRTHPLACE OF MOTHER Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Stroschein
(Address) Arden Idaho

15. July 22 26 McMurry
Filed _____ 19 _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22 26
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19 _____ to _____ 19 _____
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still born
ante partum Haemorrhage

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory Ante partum separation
(Second) Placenta
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) McMurry M. D.
July 22 1926 (Address) Arden Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Arden Idaho DATE OF BURIAL July 23 19 26

20. UNDERTAKER Quand ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH AUG 7 1906

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Blackfoot

No. East Bridge St.

Hospital 365-116 006-759

Registration District No. 121 State File No.

Primary Registration District No. 1007 Local Registrar's No. 232

CERTIFICATE OF BIRTH 143050

FULL NAME OF CHILD

Unmarried Loe
(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

} and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

July 16

(Month)

(Day)

1926
(Year)

What bactericidal solution was used in eyes?

7

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

5

FATHER
FULL
NAME

Lewis R. Loe

RESIDENCE

Blackfoot, Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

19

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

MOTHER
FULL
MAIDEN
NAME

Eva Loe

RESIDENCE

Blackfoot Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

108

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at Blackfoot Idaho U.S.A. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

F. J. Mitchell

(Physician or midwife)

Address

B.

Filed

Aug 5 1926 M. L. Waters & E. L. Loe

Registrar.

Registrar.

DEPARTMENT OF JUSTICE
BUREAU OF VITAL STATISTICS

050841 HTRM 00 072119Z

NOT RECORDED

Approved: _____ Date: _____

• 11117 7 AM 7 11117

1. The first step is to identify the problem or question that needs to be answered.

[Faint, mostly illegible text from a document page]

What bacterial infection was not identified?

1. The number of blind children in the United States is about 100,000.

RENTON

NAME
MAJOR
RANK

WENTZ

11/17
MAM

AGE AT LAST
BIRTHDAY

COLOR

TEAM 30A
YACHTING

NO JCC

ПРОДЛЮЖЕНИЕ

BIRTHPLACE

NOITAYUJCO

REPORT

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born

When this was done the following was written:

Begehrten

Index

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 7 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 54144

PLACE OF DEATH

CERTIFICATE OF DEATH

Local Registrar's No. 89

County of Bingham
City of Blackfoot

Registration District No. 2194

Primary Registration District No. 2194

(No. 1)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Unrained Doe

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 16 1924

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Blackfoot Idaho
(State or country)

10 NAME OF FATHER Louis R Lor

11 BIRTHPLACE OF FATHER (city or town) OKla
(State or country)

12 MAIDEN NAME OF MOTHER Eva Gende

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant Louis Richard Lor
(Address) Blackfoot Idaho

15 Filed July 17 1926 M. C. Walter Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16 1924
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 16 1924 to July 16 1924, that I last saw him on July 16 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Stillborn
Prémature 5 1/2 mo

(duration) yrs. mos. ds.

CONTRIBUTORY Intoxication
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. W. Mitchell M. D.
7/17, 1924 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial 19

20. Undertaker Address
none employed

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each, and the number of each, in order of birth stated.

PLACE OF BIRTH JUL 29 1926

764 2/8 104 689

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. 14 * Gooding St. Registration District No. ✓ File No. 143077
Hospital Gooding Co. Primary Registration District No. ✓ Registered No. 25
FULL NAME OF CHILD Loula Rae Paulson
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>✓</u> and Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Apr 18</u> 192 <u>6</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Mr Francis Paulson
RESIDENCE Hailey Ida
COLOR white AGE AT LAST BIRTHDAY 46 (Years)
BIRTHPLACE Manti Utah
OCCUPATION common labor

MOTHER
FULL MAIDEN NAME Rhoda Frances White
RESIDENCE Hailey Ida
COLOR white AGE AT LAST BIRTHDAY 46 (Years)
BIRTHPLACE Lochen Utah
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 8 30 A.M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. H. Seed

(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Address

Hailey Ida

Filed

7-10

192

Robert H. Wright
Registrar.

Registrar.

2025

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

614-227 014 468

County of CanyonCity of CaldwellNo. # 4 ~~St.~~ Registration District No. 3 State File No. 2Hospital _____ Primary Registration District No. 2005 Local Registrar's No. 119FULL NAME OF CHILD Baby Wade

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>7/27</u> <u>1926</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME		FULL MAIDEN NAME	
<u>Fred Wade</u>		<u>Gladys Moyer</u>	
RESIDENCE <u>R. # 4, Caldwell, Idaho</u>		RESIDENCE <u>R. # 4 Caldwell, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Missouri</u>		BIRTHPLACE <u>Kansas</u>	
OCCUPATION <u>Farming</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3:10 A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F. M. Cole(Physician or Midwife)
Caldwell, Idaho

Address _____

Filed 7-28-1926 John S. Meyer

Registrar.

Registrar.

2

DEPARTMENT OF HEALTH AND WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 1 Registration District Name State File No.

Birth Registration Number No. Local Registrar

Full Name of Child

Sex of Child Male Female

Date of Birth

Place of Birth

What bacteriological examination was made of child

Number of child of this mother including present birth

Number of child of this mother now living including present birth

Full Name of Mother

Full Name of Father

Residence of Child

Residence of Father

Color of Child

Color of Father

Birthplace of Child

Birthplace of Father

Occupation of Child

Occupation of Father

Certification of Attending Physician or Midwife

I hereby certify that I attended the birth of this child, who was born on the date above stated

When there was no attending physician or midwife, then the father, husband or mother, should make the report. A child is one that neither mother nor father ever saw before of the after birth.

Give names of other persons who reported the birth of this child.

Signature of Registrar

Signature of Father

Signature of Mother

Signature of Child

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 9 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 54185

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3

Primary Registration District No. 2006.

Local Registrar's No. 51

(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Wade

(a) Residence. No. Caldwell, Re. 4 St.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ✓ da. ✓ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Caldwell, Ida
(State or country) Re. 4.

10 NAME OF FATHER Fred Wade

11 BIRTHPLACE OF FATHER (city or town) Collins, Missouri
(State or country)

12 MAIDEN NAME OF MOTHER Gladys Meyer

13 BIRTHPLACE OF MOTHER (city or town) Wetmore, Kans.
(State or country)

14 Informant Fred Wade
(Address) Caldwell, Ida. Re. 4.

15 Filed 7-27-1926 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 27 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to July 27, 1926.
that I last saw him alive on _____, 19____,
and that death occurred, on the date stated above, at not known m.

The CAUSE OF DEATH* was as follows:

Unknown, (still born), Had
been dead two or three
days before birth.
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? ____ Date of ____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) J. S. Meyer M. D.
7/27, 1926 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal at Residence - Date of Burial 7-27-1926

20. Undertaker Fred Wade & Co. Address Caldwell, Re. 4 -

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED AUG 7 1926
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Custer
City of Challis
No. 852-120 OF 281 St. Registration District No. 1-8 State File No. 143184
Hospital _____ Primary Registration District No. 2186 Local Registrar's No. 84

FULL NAME OF CHILD Un-named
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legiti- mate? yes Date of birth June 20 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Musterir Hesser
RESIDENCE Idaho
COLOR White AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Legnascus
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Nova Mildred Shank
RESIDENCE Idaho
COLOR White AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Penn
OCCUPATION Housewife

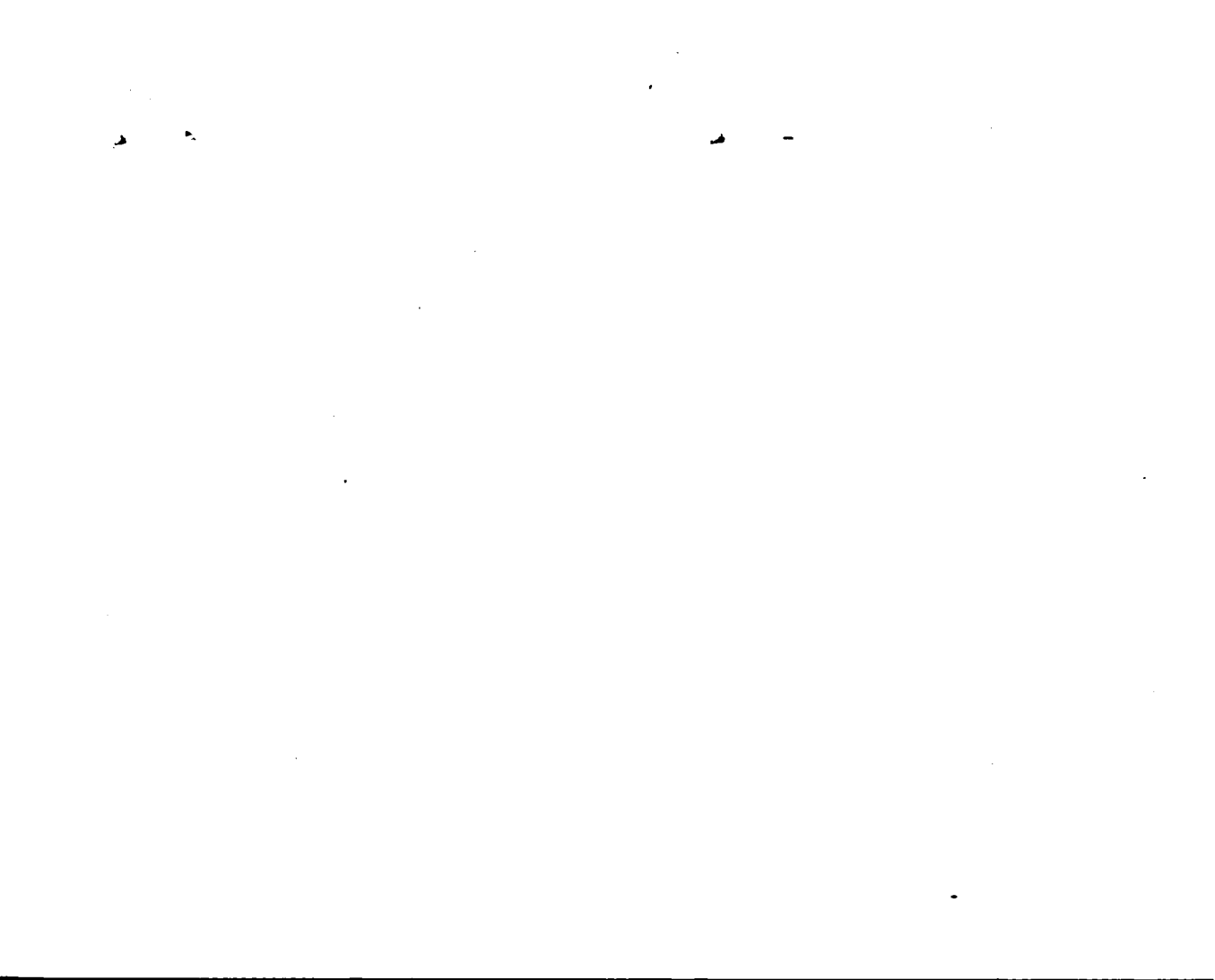
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 6:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1926
Edna M. Kenney
Registrar.

(Signature) Lois Kirtley
(Physician or midwife)
Address Challis Idaho
Filed July 31 1926 Edna M. Kenney
Registrar.



MARGIN RESERVED FOR BINDER

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V S. No. 5-25 M. 1-19

1. PLACE OF DEATH
County of Custer
City of Challis

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 108
Primary Registration District No. 2186
(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 54227
Local Registrar's No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Stillborn

6. DATE OF BIRTH

June 20 1926
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
_____ hrs. or
_____ min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF Father

Mustavix Hesson

11. BIRTHPLACE OF FATHER

(State or Country) Demarens

12. MAIDEN NAME OF MOTHER

Nora Mildred Shanks

13. BIRTHPLACE OF MOTHER

(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

July 31 1926

1926

Edna M. Kenney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 20 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19,
that I last saw him alive on 19,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. S. Kappeler M. D.
19 _____ (Address) Challis Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Challis Idaho August 1 1926

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

of ~~Franklin~~ **PRESTON** AUG 5 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

~~City~~ **Preston**

No. **68-110-021893** St. Registration District No. **27** State File No. **143194**

Hospital _____ Primary Registration District No. **2119** Local Registrar's No. **155**

FULL NAME OF CHILD **Stillborn**

(Certificate of no value without full name of child)

Sex of Child Male	Twin Triplet or other? } and } Number in order of birth	Legitimate? Yes	Date of birth July 10, 1926 (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth **8** Number of child of this mother now living, including present birth **7**

FATHER
FULL NAME **George J. Johnson**

RESIDENCE
Preston, Idaho R.F.D. #1

COLOR **White** AGE AT LAST BIRTHDAY **40**
(Years)

BIRTHPLACE **Utah**

OCCUPATION **Farming**

MOTHER
FULL MAIDEN NAME **Anna L. Hilstead**

RESIDENCE
Preston, Idaho R.F.D #1

COLOR **White** AGE AT LAST BIRTHDAY **36**
(Years)

BIRTHPLACE **Sweden**

OCCUPATION **Housewife**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was **born alive** at **11:30 P** M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature)

Physician
(Physician or midwife)
Preston, Idaho

Address _____

Filed **Aug 2, 1926**

Registrar.

Registrar.

Placenta Praevia

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

1. PLACE OF DEATH

County of FranklinCity of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME StillbornRegistration District No. 27Primary Registration District No. 2119

(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 54241Local Registrar's No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word)

6. DATE OF BIRTH

July 10, 1926

(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many
0 hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Preston, Idaho

10. NAME OF

Father George J. Johnson

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Anna L. Hilstead

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

George J. Johnson

(Informant)

(Address) Preston, Idaho ROUTE 1

15.

Filed Aug. 2 1926 R. P. Queller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10, 1926

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1926 to July 10 1926
that I last saw him alive on July 10 1926
and that death occurred on the date stated above, at 10:30 AM.

The CAUSE OF DEATH* was as follows:

Stillborn
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Placenta Previa
(Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) R. P. Queller M. D.
19 _____ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Preston, Idaho

DATE OF BURIAL

19 _____

20. UNDERTAKER

ADDRESS _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF RECEIVED AUG 7

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of FranklinCity of Clifton

CERTIFICATE OF BIRTH

27

143195

No. 25112021962 St. Registration District No. State File No.Hospital Primary Registration District No. 2119 Local Registrar's No. 156FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>July 12, 1926</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 7FULL NAME FATHER
Parley A. SearsRESIDENCE Clifton, IdahoCOLOR White AGE AT LAST BIRTHDAY 41
(Years)BIRTHPLACE UtahOCCUPATION FarmingFULL MAIDEN NAME MOTHER
Florence RobbinsRESIDENCE Clifton, IdahoCOLOR White AGE AT LAST BIRTHDAY 38
(Years)BIRTHPLACE UtahOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

Physician
(Physician or midwife)Address Preston, IdahoFiled AUG. 2, 1926

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

71
American
Monthly

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. AUG 5 1926

1. PLACE OF DEATH

County of Franklin
City of Clifton

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn

CERTIFICATE OF DEATH

Registration District No. 27
Primary Registration District No. 2119
(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 54242
Local Registrar's No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 77 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Single
(Write the word)

6. DATE OF BIRTH

July 12, 1926

(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
0 min.?

0 Yrs. 0 Mos. 0 Ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Clifton, Idaho

10. NAME OF

Father Parley A. Sears

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Florence Robbins

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Parley A. Sears
(Address) Clifton, Idaho

15.

Filed Aug 2 1926 R. P. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH 1895

16. DATE OF DEATH

July 12, 1926

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1926 to July 12, 1926
that I last saw him alive on July 12, 1926
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn
encephalic monster
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Aug 21926 (Address) M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Clifton, Idaho

DATE OF BURIAL
July 131926

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

366-202024842
PLACE OF BIRTH

RECEIVED AUG 5 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Gooding
City of Gooding
No. Gooding St. Registration District No. 24 File No. 143259
Hospital Gooding Co. Primary Registration District No. _____ Registered No. 99
FULL NAME OF CHILD Winnie G. Cooper

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	<input checked="" type="checkbox"/> Twin <input type="checkbox"/> Triplet or other?	and	Number in order of birth <u>5</u>	Legitimate? <u>Yes</u>	Date of birth <u>July 2</u> 192 <u>6</u> (Month) (Day) (Year)
----------------------------	---	-----	-----------------------------------	------------------------	--

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? 1.0% Silvol

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME William Chris Cooper
RESIDENCE Gooding

COLOR White AGE AT LAST BIRTHDAY 24.2 (Years)

BIRTHPLACE St. Louis Mo

OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Mary Huska
RESIDENCE Gooding

COLOR White AGE AT LAST BIRTHDAY 34 (Years)

BIRTHPLACE Hipto Iekla Ivachnova Hungary

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12:20 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Houston Snyder

(Physician or midwife)

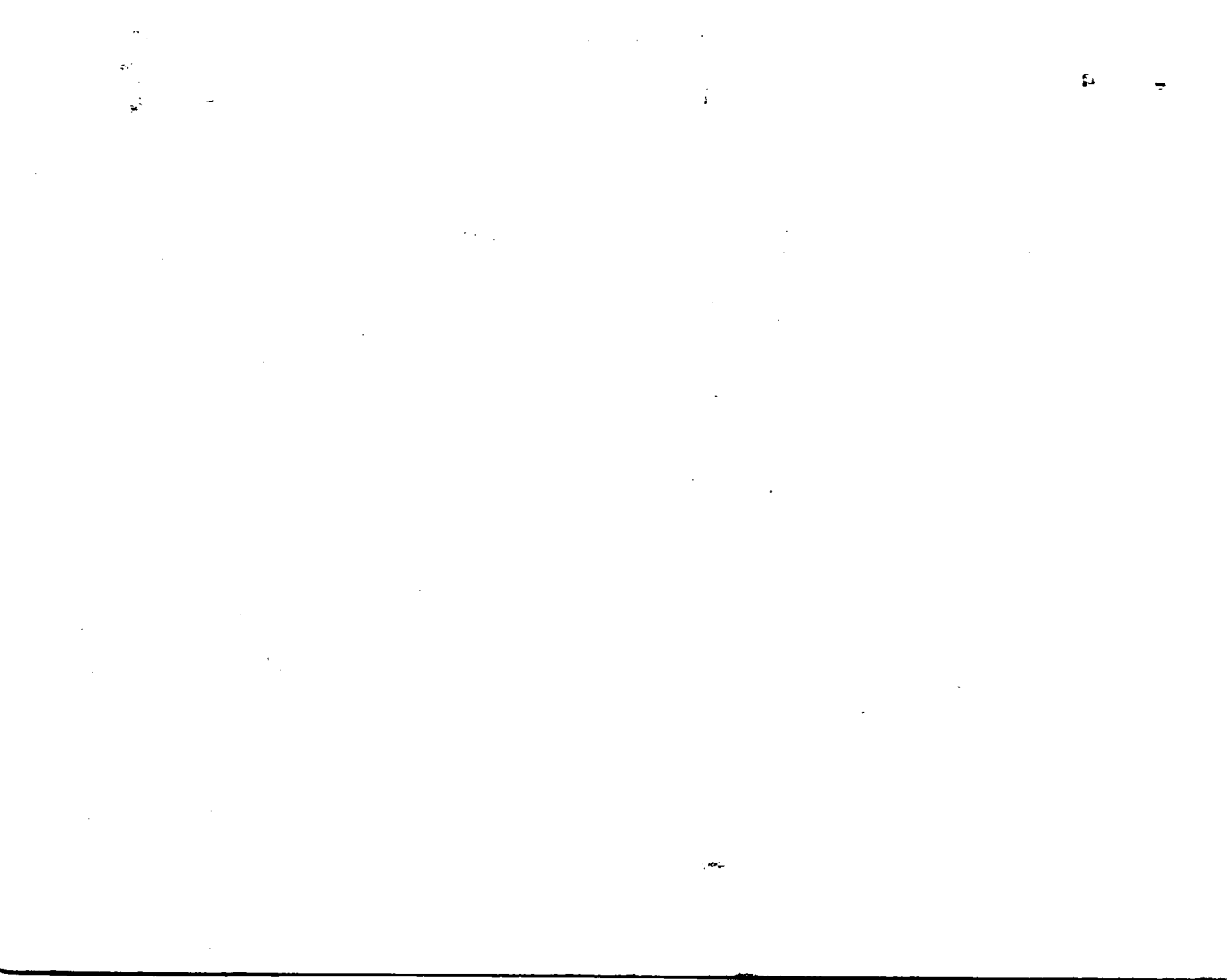
Give names added from a supplemental report.
_____, 19____

Address Gooding

Filed 7-31 1926 J. P. Cronway

Registrar.

Registrar.



FORM V. S. No. **RECEIVED AUG 5 1926**

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Gooding
City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No. _____

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 54252Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie G. Cooper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

July 2 1926
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.IF LESS than 1 day
how many _____ hrs.
or _____ min. 7

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Baby

9. BIRTHPLACE

(State or Country)

Gooding Idaho

10. NAME OF FATHER

William C Cooper

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Mary Huska

13. BIRTHPLACE OF MOTHER

(State or Country)

Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W C Cooper

(Address)

Gooding Idaho

15.

Filed 7-31-1926J H Crumrey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 2 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7-2-1926 to 7-2-1926that I last saw him alive on 7-2-1926and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Hamilton E. Snyder M.D.

19 _____

(Address)

Gooding Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19 _____

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED AUG 1 1926 DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho
City of Cottonwood
No. 264703025445 St. Registration District No. 105 State File No. 142283
Hospital _____ Primary Registration District No. 2183 Local Registrar's No. 32
FULL NAME OF CHILD Un-named

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>July 3</u> 192 <u>6</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 8

FATHER
FULL NAME Roy Romig
RESIDENCE Cottonwood Ida
COLOR White AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Iowa
OCCUPATION Day laborer

MOTHER
FULL MAIDEN NAME Nellie Dunsenmore
RESIDENCE Cottonwood Ida
COLOR White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Iowa
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:00 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Nesley C. W. M. D.

(Physician or midwife)

Address Cottonwood Ida

Filed Aug 2 1926

Registrar.

Registrar.

Exposure &
undernourishment
of mother.

RECEIVED AUG 1 1926

54257

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 105

County of Idaho

Primary Registration District No. 2183

City of Pullman

(No. St.)

File No. 11

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unmarried

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

July 3 1926
(Month) (Day) (Year)

7. AGE

21 Yrs. 10 Mos. 14 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Roy Roring

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Nettie Dunsmuir

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Roy Roring
Pullman, Idaho

15.

Filed

Aug 2 1926

1926

W. F. Orr

Local Registrar

16. DATE OF DEATH

July 3 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw him alive on 191
and that death occurred on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth, due to exposure and undernourishment of mother
(Duration) 1 Yrs. 10 Mos. 14 ds.

Contributory (Secondary)

(Signed) W. F. Orr

(Address) Pullman, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Pullman, Idaho
Roy Roring Pullman, Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLA **RECEIVED** AUG 7 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S.

CERTIFICATE OF BIRTH

143347

County of Notre Dame

City of Coeur d'Alene

No. 433122028 238

St. Registration District No. 130

State File No.

Hospital

Primary Registration District No. 1050

Local Registrar's No. 186

FULL NAME OF CHILD

John D. M. Combs
(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

}

and {

Number
in order
of birth

}

Legiti-
mate?

yes

Date of
birth

July 2

1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

2

Number of child of this mother, including present birth

4

Number of child of this mother now living, including present birth

3

FULL
NAME

FATHER

Wm E. M. Combs

FULL
MAIDEN
NAME

MOTHER

Olive Schroth

RESIDENCE

Coeur d'Alene, Ida.

RESIDENCE

Coeur d'Alene, Ida.

COLOR

White

AGE AT LAST
BIRTHDAY

28

(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

37

(Years)

BIRTHPLACE

Ida.

BIRTHPLACE

Kan.

OCCUPATION

Accountant

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

J. C. Dwyer

(Physician or midwife)

Address

Coeur d'Alene, Ida.

Filed

8/10

1926

D. D. Dwyer

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF OHIO
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____ at _____ State of _____
 Hospital _____
 Primary Registration District No. _____
 Full Name of Child _____
 (Certificate of no value without full name of child)

Sex of Child _____
 Date of Birth _____
 Place of Birth _____
 (To be answered only in case of plural births)

What pathological condition was used in case?

Number of child of this mother, including present birth _____
 Name of Father _____
 Name of Mother _____
 Full Name _____
 Maiden Name _____

Residence _____
 Color _____
 Age at Last Birthday (Years) _____

Birthplace _____
 Occupation _____

Color _____
 Age at Last Birthday _____

Birthplace _____
 Occupation _____

Color _____
 Age at Last Birthday _____

Birthplace _____
 Occupation _____

Color _____
 Age at Last Birthday _____

Birthplace _____
 Occupation _____

Color _____
 Age at Last Birthday _____

Birthplace _____
 Occupation _____

Color _____
 Age at Last Birthday _____

Birthplace _____
 Occupation _____

Color _____
 Age at Last Birthday _____

THIS CERTIFICATE IS A PART OF THE RECORDS OF THE BUREAU OF VITAL STATISTICS, DEPARTMENT OF HEALTH, STATE OF OHIO. IT IS TO BE KEPT IN THE FILES OF THE BUREAU AND NOT DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE ORDER OF THE COMMISSIONER OF HEALTH.

I hereby certify that I attended the birth of this child, and that the child was born _____
 and was alive at birth.
 I have signed this certificate as a true and correct statement of the facts as they occurred.
 Signature of Physician _____
 Address _____
 Date _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 7 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 54267

Local Registrar's No. 1479

PLACE OF DEATH

County of Kootenai

Registration District No. 30

City of Coeur d'Alene

Primary Registration District No. 1081

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. 815 - 7th St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) 7-2-1926

7 AGE Years Months Days 0 0 0 If LESS than 1 day, 2 hrs. or 2 min.

8 OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'Alene (State or country) Idaho

10 NAME OF FATHER W. E. Mc Combs

11 BIRTHPLACE OF FATHER (city or town) Kentucky (State or country)

12 MAIDEN NAME OF MOTHER Olive Schroth

13 BIRTHPLACE OF MOTHER (city or town) Kan. (State or country)

14 Informant W. E. Mc Combs (Address) 915 Seventh St Coeur d'Alene

15 Filed 8/10, 1926 W. E. Mc Combs Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 2 1926 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born. Death occurring about 4 days prior to delivery. Cause not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Jones M. D. July 2, 1926 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Forest Cem. Coeur d'Alene 7-3 1926

20. Undertaker C. Cassidy Address Coeur d'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker, or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
RECEIVED AUG 7 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

143349

County of Kootenai

City of Coeur d'Alene

No. 285-112-028 291 St.

Registration District No. 30

State File No.

Hospital

Primary Registration District No. 1007

Local Registrar's No. 1609

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>July 12 1926</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 11 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME William James Sheffield
RESIDENCE 1611 Coeur d'Alene Ave.
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Idaho
OCCUPATION Groceryman

MOTHER
FULL MAIDEN NAME May Louise Krundelt
RESIDENCE 1611 Coeur d'Alene Ave.
COLOR White AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Spokane Washington
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 3 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
, 192

(Signature) Charles J. King M.D.
(Physician or midwife)

Address Coeur d'Alene Idaho

Filed 8/10 1926 D. B. [unclear] Registrar.

Registrar.

Compression of
umbilical cord.

RECEIVED AUG 7

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 54277

PLACE OF DEATH

County of Post
City of IdahoRegistration District No. 30
Primary Registration District No. 2051Local Registrar's No. 147F

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Jennings Sheffield(a) Residence. No. 16116 D.A. Ave St.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'Alene
(State or country)10 NAME OF FATHER William Jennings Sheffield11 BIRTHPLACE OF FATHER (city or town) Bozeman Idaho
(State or country)12 MAIDEN NAME OF MOTHER Krandell13 BIRTHPLACE OF MOTHER (city or town) Spokane Wash
(State or country)14 Informant W. J. Sheffield
(Address) 16116 D.A. St.15 Filed 8/10 1926 W. J. Sheffield Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 12 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born - Death
caused by compression
of umbilical cord -
(duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death? _____
(duration) _____ yrs. _____ mos. _____ ds.

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Harold J. Sturges, M. D.
July 12, 1926 (Address) Coeur d'Alene Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Forest cemetery 1920 Undertaker Bozeman Address Bozeman

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 7 1926

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic Interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

SS3721-038-356
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

143470

County of Payette
City of Payette

CERTIFICATE OF BIRTH

No. — St. — Registration District No. 4 State File No. —

Hospital — Primary Registration District No. 1008 Local Registrar's No. 52

FULL NAME OF CHILD Marion Lewis Nelson

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? — and — Number in order of birth 1 Legitimate? yes Date of birth June 21- 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Franklin M Nelson
RESIDENCE Arundell Idaho
COLOR white AGE AT LAST BIRTHDAY 47 (Years)
BIRTHPLACE North Dakota
OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Sarah E Lewis
RESIDENCE Arundell Idaho
COLOR white AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 3:30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Registrar.

Registrar.

1. I have been advised that I attended the birth of

the date above stated.

1. I was born on 10/10/1910 at [redacted] and I attended the birth of this child, who was [redacted] at [redacted] on 10/10/1910.

What practical use will be made in 1957?

10-248
61123

(Continued on inside back cover)

CHILD NAME OF CHILD

Regulation District No. 7

JOINT STATEMENT OF BIRTH

DEPARTMENT OF JUSTICE
BUREAU OF PRISONS

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No. _____ St.)

State File No. 54300
Local Registrar's No. 28

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marian Lewis Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED single
(Write the word)

6. DATE OF BIRTH June 21 1926
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day how many
Yrs. Mos. ds. 0 hrs. or 0 min.?

8. OCCUPATION baby
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Franklin M. Nelson

11. BIRTHPLACE OF FATHER N. Dak.
(State or Country)

12. MAIDEN NAME OF MOTHER Sarah E. Lewis

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Franklin M. Nelson
(Address) Payette, Idaho

15. Filed July 24 1926 J. G. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/21 1926 to 6/21 1926
that I last saw him alive on 6/21 1926
and that death occurred on the date stated above, at 3:30 P. M.
The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary) _____
(Duration) — yrs. — mos. — ds.
(Signed) James C. Bartlett M. D.
6/20/26 (Address) Ontario Oregon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Payette, Idaho DATE OF BURIAL June 22 1926
20. UNDERTAKER Glenn Gordon ADDRESS Payette, Idaho

state CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate. Very important.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lober pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
816-234 042 415
County of Lincoln
City of Twin Falls

STATE OF IDAHO RECEIVED
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

AUG 9 1926
S 43516

CERTIFICATE OF BIRTH

No. St. Registration District No. 370 State File No.
Hospital Twin Falls Co. Primary Registration District No. 1085 Local Registrar's No.

FULL NAME OF CHILD Joan Marie Hawkins
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u> } and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>7-24</u> 192 <u>6</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Arthur Everett Hawkins
RESIDENCE Piler Idaho
COLOR W hite AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Emma Marie Davenport
RESIDENCE Piler Idaho
COLOR W hite AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:15 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 1926

(Signature) H. A. Dwight M. D.
(Physician or midwife)

Address Twin Falls Idaho
Filed Aug 1926 John F. Longkin Registrar.

Registrar.

DECLARATION OF BIRTH

Registration District No. 100

Primary Registration District No. 100

(Certificate of no child without full name of child)

Full name of child in English (Printed)
 Date of birth (Printed)
 Sex (Printed)
 Color (Printed)

MOTHER

FATHER

AGE AT LAST BIRTHDAY

AGE AT LAST BIRTHDAY

BIRTHDAY

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN

I hereby certify that I attended the birth of this child, who was born on the 10th day of the month of January, 1900, at the residence of the mother, and that the child was born alive, full term, and healthy.

(Signature of Physician)

Physician

Address

I hereby certify that I attended the birth of this child, who was born on the 10th day of the month of January, 1900, at the residence of the mother, and that the child was born alive, full term, and healthy.

(Signature of Physician)

Physician

Address

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

615 116 044-363

County of

Washington

City of

Waver

No.

St.

Registration District No.

86

File No.

Hospital

Primary Registration District No.

R. J. D. # I 2112

Registered No.

50

FULL NAME OF CHILD

Baby Warrick

(Certificate of no value without full name of child.)

Sex of
Child

male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

6/16/

1926

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

5

Number of child of this mother now living, including present birth

2

FULL
NAME

FATHER

John J. Warrick

RESIDENCE

Waver

FULL
MAIDEN
NAME

MOTHER

Guatys Edna Colvig

RESIDENCE

Waver

COLOR

white

AGE AT LAST
BIRTHDAY

44

(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

29

(Years)

BIRTHPLACE

Penn

BIRTHPLACE

Oregon

OCCUPATION

farmer

OCCUPATION

house wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

stillborn

at

3:30 P. M.

(If ~~born~~ stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

F. A. Schumacher M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Waver, Idaho

Filed

July 14, 1926

W. R. Kammeln

Registrar.

Registrar.

607

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

133-3954
PLACE OF BIRTH

County of Ada

City of Boise

No. Birth School District

Hospital

FULL NAME OF CHILD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED

SEP 3-

CERTIFICATE OF BIRTH

Register District No. 8 State File No. 143599

Primary Registration District No. 2008 Local Registrar's No. 56

(Certificate of no value without full name of child)

Sex of Child

7

Twin
Triplet
or other?

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

Aug 13 -

1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FULL
NAME

FATHER

Jordan M. G. Allen

RESIDENCE

Boise, Ida.

COLOR

AGE AT LAST
BIRTHDAY

21
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Chief

FULL
MAIDEN
NAME

MOTHER

Verla Marie Tiede

RESIDENCE

Boise, Ida.

COLOR

AGE AT LAST
BIRTHDAY

18
(Years)

BIRTHPLACE

Idaho

OCCUPATION

St. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7:45 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

1926

Registrar.

(Signature)

John B. Beck

(Physician or midwife)

Address

Boise

Filed

Aug 30 1926

Registrar.

CONFIDENTIAL

No. 100-100000

.....

(Continued on next page, full name of child)

10-8-55

10-10-68

Number of child of this mother : now living, including present birth

SMALL

RESIDENCE _____ RESIDENCE _____

1945 JAN 10 10 10 AM '45

100-443887-100

10-11-68

CERTIFICATE OF ATTENDING PHYSICIAN ON BIRTH:

12 I further certify that I attended the birth of this child who was born on

(SIXTEEN)

shows other evidence of his after birth

REF ID: A58108

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

STATE OF IDAHO
SEP 3 DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH Idaho BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County of Ada Registration District No. 8
City of Boise Primary Registration District No. 2008
(No. _____)

DO NOT WRITE IN THIS SPACE

State File No. 54354

Local Registrar's No. 454

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Allen

(a) Residence. No. near Whitney School St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Aug 13 - 1926

7 AGE Years Months Days 1 If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Idaho
(State or country)

10 NAME OF FATHER Gordon M. Allen

11 BIRTHPLACE OF FATHER (city or town) Iowa
(State or country)

12 MAIDEN NAME OF MOTHER Verla Pede

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant Chas J. Allen
(Address)

15 Filed Aug 16, 1926 R. H. Pate Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 13 19 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 13 19 26 to Aug 13 19 26.
that I last saw her alive on Aug 13 19 26.
and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

subcoronary thrombosis due to strangulation by umbilical cord.
(duration) Stillborn mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Chas J. Allen M. D.
Aug 14 19 26 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Morris Hill Cem. Date of Burial Aug 14 19 26

20. Undertaker Summers & Sons Address Boise, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicæmia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

319-214 003-319
PLACE OF BIRTH
RECEIVED AUG 14 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
County of Bannock
City of Pocatello
CERTIFICATE OF BIRTH
No. General St. Registration District No. 28 State File No. 143663
Hospital General Primary Registration District No. 2161 Local Registrar's No. 7666
FULL NAME OF CHILD Babe Larson (Stillborn)
(Certificate of no value without full name of child)

Sex of Child F Twin Triplet or other? - and { Number in order of birth - } Legitimate? yes Date of birth 6-14-1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0
FULL NAME FATHER Victor Larson FULL MAIDEN NAME MOTHER Steele Larson
RESIDENCE Pocatello RESIDENCE Pocatello
COLOR W AGE AT LAST BIRTHDAY 33 (Years) COLOR W AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Utah. BIRTHPLACE Utah.
OCCUPATION Electrician OCCUPATION W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Steele Larson

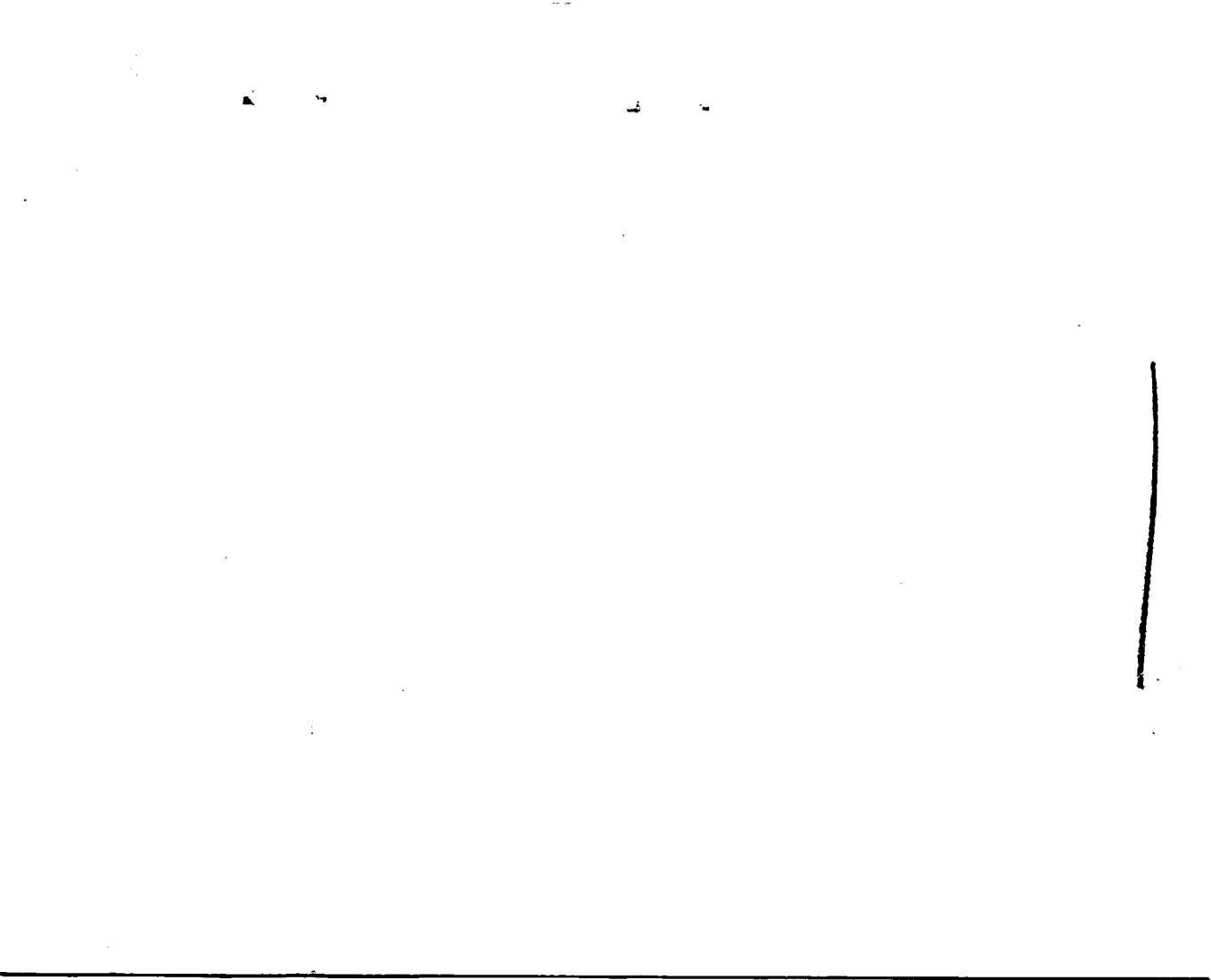
(Physician or midwife)

Address Pocatello.

Filed 8/1-1926

Registrar.

Registrar.



RECEIVED JUL 10 1926

FORM V. S. No. 3-25 M-7-10

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock

City of Poratello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2161

(No. Gen. Hospital St.)

State File No. 4

Local Registrar's No. 4835

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Infant Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word)

6. DATE OF BIRTH

Still-born

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day how many

hrs. or

min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Poratello

10. NAME OF

Father

U. R. Larsen

11. BIRTHPLACE

OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME

OF MOTHER

"

13. BIRTHPLACE

OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

U. R. Larsen

(Address)

Poratello Idaho

15.

Filed June 19 1926

J. H. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn
June 14

(Month)

(Day)

1926
(Year)

17.

I HEREBY CERTIFY, That I attended deceased from 6-14 1926 to 6-14 1926

that I last saw him alive on 1926

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn
Cause - Unknown

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frederick

M. D.

6/19/26

(Address)

Poratello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence Poratello

19. PLACE OF BURIAL OR REMOVAL

mt View

DATE OF BURIAL

1926

20. UNDERTAKER

M. H. and Co

ADDRESS

Poratello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

469130 003 897
PLACE OF BIRTH

RECEIVED AUG 1 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Pocatello

No. _____ St. _____

Hospital St. Anthony

Registration District No. 28

File No. 143704

Primary Registration District No. 2161

Registered No. 7707

FULL NAME OF CHILD James Perry Morrow

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> and <u> </u> Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Mar. 30</u> 192 <u>6</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Perry Morrow
RESIDENCE Blackfoot, Idaho
COLOR white AGE AT LAST BIRTHDAY 51 (Years)
BIRTHPLACE Waldron Missouri
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Alice Rose High
RESIDENCE Blackfoot, Idaho
COLOR white AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Seneca Falls N. Y.
OCCUPATION Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 4:50 A. M. on the date above stated. (born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. H. Hugbart M.D.
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Home Bldg. Pocatello, Idaho
Filed 8/1 1926 H. Young Registrar.

RECEIVED BY THE BUREAU OF VITAL STATISTICS, NEW YORK CITY, FROM THE NEW YORK CITY DEPARTMENT OF HEALTH, BUREAU OF VITAL STATISTICS, ON MAY 1, 1935.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Full Name of Child: **JOHN J. BROWN**
 Primary Registration District No. **2161**
 Registration District No. **2161**
 Sex of Child: **Male**
 Date of Birth: **April 1, 1935**
 Legitimacy: **Legitimate**
 Number of Children of this Mother: **2**
 Number of Children of this Father: **2**
 Full Name of Mother: **MARY J. BROWN**
 Full Name of Father: **JOHN J. BROWN**
 Residence: **1234 5th Ave., New York City**
 Color: **White**
 Age at Last Birthday: **34**
 Birthplace: **New York City**
 Occupation: **Teacher**
 Birthplace: **New York City**
 Age at Last Birthday: **34**
 Color: **White**
 Residence: **1234 5th Ave., New York City**
 Full Name of Mother: **MARY J. BROWN**
 Full Name of Father: **JOHN J. BROWN**

CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE
 I hereby certify that I attended the birth of this child, and was present at the birth of this child.
 Signature: **Dr. J. J. Brown**
 Address: **1234 5th Ave., New York City**
 Date: **April 1, 1935**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

MAY 19

DO NOT WRITE IN THIS SPACE

53386

State File No.

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bannock

BUREAU OF

Registration District No. 28City of PorterPrimary Registration District No. 216Local Registrar's No. 4793(No. St. Anthony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Morrow

(a) Residence. No. _____

St. _____

Blackfoot Idaho

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

March 30 - 1926

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.Stillborn

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Stillborn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)PortervilleIdaho

10 NAME OF FATHER

Curry Morrow11 BIRTHPLACE OF FATHER (city or town)
(State or country)Missouri

12 MAIDEN NAME OF MOTHER

Ellice High13 BIRTHPLACE OF MOTHER (city or town)
(State or country)New York

14

Informant
(Address)Curry MorrowBlackfoot Idaho

15

Filed

4/6 1926J. H. Huggins
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 30
(Month) (Day)1926
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

3/30, 1926, to 3/30, 1926.that I last saw him alive on Born dead 3/30, 1926.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

cause unknown child died in utero about 48 hours before delivery.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) St. H. Huggins, M. D.3/31, 1926. (Address) Kane Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Mountain View CemMarch 31, 1926

20. Undertaker

Address

Schumacher & HallPorterville

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED SEP 4 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Twelve
S

County of Bea. Lake

City of Raymond

CERTIFICATE OF BIRTH

No. 551203004294 St. Registration District No. 52 State File No. 143787

Hospital _____ Primary Registration District No. 2136 Local Registrar's No. _____

FULL NAME OF CHILD Baby Evans

(Certificate of no value without full name of child)

Sex of Child Female ☒ Twin ☐ Triplet ☐ or other? } and { Number in order of birth 1 Legitimate? yes Date of birth July 3 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Udell L. Evans
RESIDENCE Raymond Ida
COLOR White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Winifred Kimball
RESIDENCE Raymond Ida
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Utah
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive ☐ Stillborn ☒ at 5 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Montpelier, Idaho

Address Montpelier, Idaho

Filed 9/6/1926

Registrar.

Registrar.

*Mother died
of blood poisoning*

195
Revised.

on the above stated.

1878/30H

78:011.54.

TEA TALK
YACHTING

10A 1987 F 12
1001740000

NAME
ADDRESS
CITY

॥ श्रीगणेशाय नमः ॥

2979 ni 2000-aw noli-doi lchibidobad

REF ID: A66084

11-29-11
1-13-12

(S) (U)

0.2 (H) 50 W

100-443886-100

10-11-1964
State File No. 10-11-1964

(DECLASSIFICATION OF RECORD)

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

785641

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 4 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 54425

PLACE OF DEATH

County of Bear Lake
City of Raymond

Registration District No. 52
Primary Registration District No. 2136
(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Evans - (Not Named)

(a) Residence. No. Raymond St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (Write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Still Born

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days Never Breathed If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Still Born Infant
(b) General nature of industry, business, or establishment in which employed (as employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Raymond Idaho
(State or country)

10 NAME OF FATHER Andy L. Evans

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Winifred Kimmel

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant Andy L. Evans
(Address) Raymond Idaho

15 Filled 9/11 1926 H. H. Keig
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 3 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 3 1926 to July 3 1926
that I last saw him alive on July 3 1926
and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Stillborn Cause - (6 mos. gestation)
Mother died of Normal Preterm at
Delivery - (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTOR (Secondary) ____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? ____ Date of ____

Was there an autopsy? No

What test confirmed diagnosis? H. H. Keig M. D.

(Signed) July 3 1926 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Raymond Idaho Date of Burial July 5 1926

20. Undertaker J. H. Williams Address Montpelier

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic Interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED SEP 4 1926 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

J. W. W.
S
143788

County of Bear Lake
City of Raymond
No. 551103004 2972 St. Registration District No. 52 State File No. 2136
Hospital 5442 Primary Registration District No. 2136 Local Registrar's No. 2136

FULL NAME OF CHILD Baby Evans
(Certificate of no value without full name of child)

Sex of Child Male ☒ Twin Y and { Number in order of birth 2 Legitimate? Yes Date of birth July 3 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>Clyde L. Evans</u>	FULL MAIDEN NAME	<u>Winifred Kimball</u>
RESIDENCE	<u>Raymond Id.</u>	RESIDENCE	<u>Raymond Id.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>40</u> (Years)	AGE AT LAST BIRTHDAY	<u>38</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at Sosona N. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Address

Filed

Registrar.

Registrar.

2

1938

Registration District No. 1938

Local Registrar

NAME OF CHILD

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE AT LAST BIRTHDAY

COLOR

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at

Address

1938

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 4 1926
State of Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 54424

PLACE OF DEATH

County of Bear Lake
City of Raymond

CERTIFICATE OF DEATH

Registration District No. 52
Primary Registration District No. 2136
(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Baby Evans - (Not Named)

(a) Residence. No. Raymond Ida St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Steel Bore

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days Never Breathed If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Steel Bore Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Raymond Idaho

10 NAME OF FATHER

Andy L. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Winifred Kumbel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Utah

14

Informant
(Address)

Andy L. Evans
Raymond Idaho

15

Filed

9/11 1926

HA King

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 3rd 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 3 1926 to July 3 1926
that I last saw him alive on _____ 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Unknown Cause - (6 mos. gestation)
Mother died of Placenta Previa at
delivery - (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? no

What test confirmed diagnosis? St. H. King M. D.

(Signed) July 3rd 19-26 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Raymond Ida

Date of Burial

July 5 1926

20. Undertaker

J. M. Williams

Address

Montpelier
Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED SEP 4 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Blackfoot

No. RDA W St.

Hospital 515-230006-235

Registration District No. 121

State File No. 143838

Primary Registration District No. 2144

Local Registrar's No. 284

CERTIFICATE OF BIRTH

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

Female

Twin
Triplet
or other?

4 and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

Aug 30 1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

6

Number of child of this mother now living, including present birth

4

FULL
NAME

FATHER

Jacob L. Van Orden

RESIDENCE

Blackfoot

COLOR

White

AGE AT LAST
BIRTHDAY

37
(Years)

BIRTHPLACE

Utah

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Minnie Skubersand

RESIDENCE

Blackfoot

COLOR

White

AGE AT LAST
BIRTHDAY

33
(Years)

BIRTHPLACE

Germany

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive ~~born~~ at 11:20 A M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Billborn
W W Beck

(Physician or ~~midwife~~)

Address

Blackfoot, Ida

Filed

Sept 2 1926

Registrar.

Registrar.

RECEIVED SEP 4 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

54445

State File No.

PLACE OF DEATH

CERTIFICATE OF DEATH

County of BinghamRegistration District No. 121City of Blackfoot, IdaPrimary Registration District No. 2194Local Registrar's No. 102

(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Stillborn - Van Orden(a) Residence. No. Blackfoot, Ida St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Aug 30, 1926

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Blackfoot, Idaho

10 NAME OF FATHER

Jacob A. Van Orden11 BIRTHPLACE OF FATHER (city or town)
(State or country)Utah

12 MAIDEN NAME OF MOTHER

Minnie Skubessand13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Germany

14

Informant
(Address)J. L. Van Orden
Blackfoot B. 2

15

Filed

Aug 30, 1926
J. L. Van Orden
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Stillborn

(Month)

(Day)

1926
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn could not
determine cause
(duration) ____ yrs. ____ mos. ____ ds.CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. Bick M. D.Aug 30, 1926 (Address) Blackfoot, Ida*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation or Removal

Date of Burial

Rossie Thomas Aug 30, 1926

20. Undertaker

Address

J. L. Van Orden

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
CUPATION is very important. See instructions on back of certificate.

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

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Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED SEP 7 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

495-208 009 268

County of Bonner

City of Sandpoint

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 76 State File No. 143877

Hospital Page Primary Registration District No. 2153 Local Registrar's No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Female { Twin Triplet or other? } and { Number in order of birth } Legitimate? yes Date of birth Aug 8 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Clifton Klingley
RESIDENCE Clarkfork, Ida.
COLOR White AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Heron, Mont.
OCCUPATION Woodsman

MOTHER
FULL MAIDEN NAME Amelia Kohler
RESIDENCE Clarkfork
COLOR White AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE Hope, Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3:30 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 192____

(Signature)

(Physician or midwife)

Address

Filed

Registrar.

Registrar.

Asperity Xica, Difficult Labor

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 7 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 54455

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville
City of Sandpoint

Registration District No. 77
Primary Registration District No. 3155
(No. _____)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Infant, [REDACTED] Dingley

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Aug 8, 1926

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Sandpoint, Idaho
(State or country)

10 NAME OF FATHER Clifton Dingley

11 BIRTHPLACE OF FATHER (city or town) Heron Mont.
(State or country)

12 MAIDEN NAME OF MOTHER Amelia Mohler

13 BIRTHPLACE OF MOTHER (city or town) Hopewell, Idaho
(State or country)

14 Informant Clifton Dingley
(Address) Clark Fork, Ida

15 Filed Aug 9, 1926 Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 8, 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,
that I last saw h_____ alive on _____, 19____,
and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Asphyxia
Shelton

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Difficult Labor
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis?
(Signed) O. F. Page M. D.
Aug 9, 1926 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Lakeview Cemetery Date of Burial Aug 10, 1926
20 Undertaker L. G. Moon Address Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

143942

County of ButteCity of ArcoNo. 359 22002-619 St.

Registration District No. _____ State File No. _____

Hospital _____

Primary Registration District No. _____ Local Registrar's No. 81

FULL NAME OF CHILD _____

☒ Not named

(Certificate of no value without full name of child)

Sex of Child FemaleTwin
Triplet
or other?

and

Number
in order
of birthLegiti-
mate? YesDate of
birth Aug 20 1926
(Month) (Day) (Year)What bactericidal solution was used in eyes? 10 ergolNumber of child of this mother, including present birth 1Number of child of this mother now living, including present birth 1FULL NAME FATHER Dan SuterRESIDENCE Arco Ida.COLOR WhiteAGE AT LAST
BIRTHDAY 20
(Years)BIRTHPLACE Mo.OCCUPATION FarmerFULL
MAIDEN
NAME

MOTHER

RESIDENCE Arco Ida.COLOR WhiteAGE AT LAST
BIRTHDAY 18
(Years)BIRTHPLACE Ida.OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ☒ Born alive ☐ Stillborn at Arco Ida. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. J. Harrison

(Physician or midwife)

Address Arco, IdahoFiled Aug 21 1926

Registrar.

Registrar.

Monstrous.

RECEIVED SEP 10 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

54486

State File No.

Local Registrar's No.

PLACE OF DEATH

County of ButteRegistration District No. 59City of ArcoPrimary Registration District No. 2129(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Still born. Not named.

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6 DATE OF BIRTH (month, day and year) Still born.7 AGE Years Months Days
0 0 0
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Arco, Ida
(State or country)10 NAME OF FATHER Don Leeter11 BIRTHPLACE OF FATHER (city or town) mo
(State or country)12 MAIDEN NAME OF MOTHER Malba Farmer13 BIRTHPLACE OF MOTHER (city or town) Utah
(State or country)14 Informant Don Truitt
(Address) Arco, Idaho15 Filled Aug. 20, 1926

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

8 20 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Born
(monstrosity)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____
if not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) E. J. Porter, M.D.8-21, 1926 (Address) Arco, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Arco, IdahoAug. 21, 1926.

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLA... OF IDAHO
OF PUBLIC WELFARE
VITAL STATISTICS
County of...
City of...
No. 632...
State File No. 143992
Hospital...
Primary Registration District No. 2196 Local Registrar's No. 3409

FULL NAME OF CHILD Baby Olson
(Certificate of no value without full name of child)

Sex of Child girl ☒ Twin ☐ Triplet ☐ and { Number in order of birth 2nd Legiti-
mate? yes Date of birth June 27 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? R. S. N. O. 3

Number of child of this mother, including present birth 14 Number of child of this mother now living, including present birth 10

FATHER		MOTHER	
FULL NAME	<u>C. M. Olson</u>	FULL MAIDEN NAME	<u>Alice Wansberg</u>
RESIDENCE	<u>Merley, Ida.</u>	RESIDENCE	<u>Merley, Ida.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>58</u> (Years)	AGE AT LAST BIRTHDAY	<u>38</u> (Years)
BIRTHPLACE	<u>Denmark</u>	BIRTHPLACE	<u>Kansas</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Teacher</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ☒ Born alive ☐ at 10 20 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) L. H. Butler
2227
(Physician or midwife)

Address Merley, Ida.

Filed July 1st 1926 Dr. J. C. Patterson

Registrar.

Registrar.



Q02

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED SEP 3 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Clatsop

City of Burley

No. 632-127016-791 St.

Registration District No.

State File No. 143993

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

Baby Olson

(Certificate of no value without full name of child)

Sex of Child

Boy

☒ Twin
☐ Triplet
or other?

and

Number
in order
of birth 1st

Legiti-
mate? yes

Date of
birth June 27 1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes? A. G. H. O.

Number of child of this mother, including present birth 13

Number of child of this mother now living, including present birth 9

FULL
NAME

FATHER

C. M. Olson

RESIDENCE

Burley, Ida.

COLOR

White

AGE AT LAST
BIRTHDAY 58
(Years)

BIRTHPLACE

Hannum

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Alice Gransbury

RESIDENCE

Burley, Ida.

COLOR

White

AGE AT LAST
BIRTHDAY 39
(Years)

BIRTHPLACE

Kansas

OCCUPATION

mother

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Stillborn at 10:15 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

F. Hunter
M.D.

(Physician or midwife)

Address

Burley, Ida.

Filed

July 1st 1926

1926

Dr. J. C. Patterson
Registrar.

Registrar.

[illegible]

19

There were no attending physicians or nurses taken into consideration in making this report. A stipulation is that neither brother nor child is one of the latter group. Showed other evidence of the latter group.

... saw a person who I attended the birth of this child, who was ...

CERTIFICATE OF ATTENDING PHYSICIAN OR NURSE:

OCCUPATION

DATE

AGE AT LAST BIRTHDAY

RESIDENCE

NAME
FULL
NAME
FULL
NAME
FULL

4. Financial report of the subject, including present and

...leave at home and collection in the morning and in the

The above is a true and correct copy of the original as the same is on file in the office of the Secretary of the Board of Education, New York City.

(Certificate of no child without full name of child)

10/10/1941

Registration District No. [redacted] Page 116

DEATH TO FEARFULNESS

SECRET

WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

753 111 220-719

PLACE OF BIRTH

STATE OF **MISSISSIPPI**
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

S

County of **Elmore** RECEIVED SEP 2 1926

City of **Glenn's Ferry**

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. **36** No. **144048**

Hospital _____ Primary Registration District No. **302** Registered No. _____

FULL NAME OF CHILD **Monr. Peterson**

(Certificate of no value without full name of child.)

Sex of Child Male	Twin Triplet or other? _____	and _____	Number in order of birth 2	Legitimate? yes	Date of birth July 11, 1926 (Month) (Day) (Year)
--------------------------	------------------------------	-----------	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? **None**

Number of child of this mother, including present birth. **3** Number of children of this mother now living, including present birth. **1**

FATHER
FULL NAME **William M. Peterson**
RESIDENCE **Glenn's Ferry Idaho**
COLOR **White** AGE AT LAST BIRTHDAY **38** (Years)
BIRTHPLACE **Wisconsin**
OCCUPATION **Transfer Service**

MOTHER
FULL MAIDEN NAME **Lillian Carl**
RESIDENCE **Glenn's Ferry Idaho**
COLOR **White** AGE AT LAST BIRTHDAY **24** (Years)
BIRTHPLACE **Idaho**
OCCUPATION **Housewife**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was **July 11, 1926** at **Glenn's Ferry, Idaho** **3** **A. M.**
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) **J. W. Davis**
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 192_____

Registrar.

Address **Glenn's Ferry Idaho**
Filed **July 15, 1926** **J. W. Davis**
Registrar.



Don

PLACE **RECEIVED** SEP 2 1926

849-105-020-851

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Elmore
City of Glenns Ferry

No. _____ St. _____ Registration District No. 35 File No. 144053
Hospital _____ Primary Registration District No. 2021 Registered No. _____

FULL NAME OF CHILD St. 111 birth

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	<u>Twin</u> Triplet <u>X</u> } and { <u>Number</u> or other? } in order (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>Aug. 5,</u> <u>1926</u> (Month) (Day) (Year)
-----------------------	--	------------------------	--

What bactericidal solution was used in eyes? X
Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

FULL NAME <u>FATHER</u> <u>Wm R. Quigley</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Hilda Yeamans</u>
RESIDENCE <u>Glenns Ferry</u>	RESIDENCE <u>Glenns Ferry</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Utah</u>
OCCUPATION <u>Firelighter</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was St. 111 born at 7:10 A. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. W. Boers

(Physician or midwife)

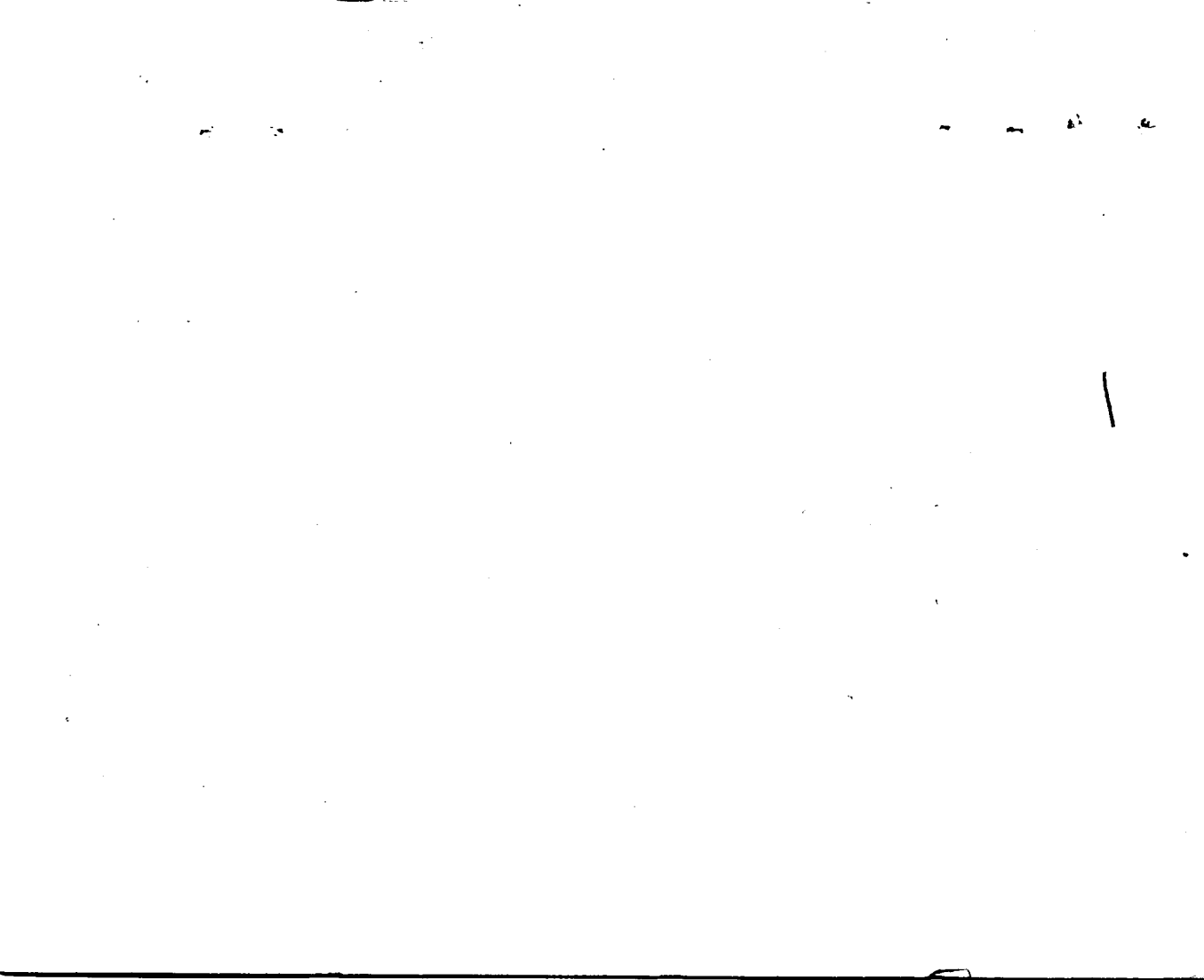
Give names added from a supplemental report.

Address Glenns Ferry, Ida

Filed Aug. 31 1926 J. W. Boers

Registrar.

Registrar.



RECEIVED SEP 2 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 54514

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Elmore Registration District No. 35
City of Glenns Ferry Primary Registration District No. 2021

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Will Birch - Gugley

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) at home

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofEmile6 DATE OF BIRTH (month, day and year) Aug. 5 - 1926

7 AGE Years Months Days If LESS than 1 day 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Glenns Ferry, Idaho
(State or country)10 NAME OF FATHER William R. Quigley11 BIRTHPLACE OF FATHER (city or town)
(State or country) Idaho12 MAIDEN NAME OF MOTHER Hilda Mary Yeaman13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Idaho14 Informant William R. Quigley
(Address) Glenns Ferry, Ida15 Filed Aug. 6, 1926 J. W. Davis
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 5 - 1926
(Month) (Day) (Year)17 Aug. 5, 1926, to Aug 5, 1926,
that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillbirth

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) G. W. Berkey M. D. 8/5, 1926 (Address) Glenns Ferry*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.19 Place of Burial, Cremation, or Removal Glenns Ferry Date of Burial 8/5 192620. Undertaker J. W. Davis Address Glenns Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ORIGINAL PRESERVED FOR DIVULGING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

436-113035-285
PLACE OF BIRTH RECEIVED SEP 8 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

144207

County of Mag. Price

City of _____

No. _____ St. _____

Registration District No. 63

File No. _____

Hospital _____

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD un named

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twins Triplet or other?	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Apr 13</u> 192 <u>6</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacterioidal solution was used in eyes? _____

Number of child of this mother, including present birth 6th Number of child of this mother now living, including present birth 5th

FATHER
FULL NAME Samuel Evert McFeron
RESIDENCE Leland

MOTHER
FULL MAIDEN NAME Dessie Bell Byers
RESIDENCE Leland

COLOR white AGE AT LAST BIRTHDAY 32
(Years)

COLOR white AGE AT LAST BIRTHDAY 28
(Years)

BIRTHPLACE Oregon

BIRTHPLACE Washington

OCCUPATION Blacksmith

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 1:00 P. M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. T. Seely M. D.

Give names added from a supplemental report.

(Physician or midwife)
Address Kendrick Sta.

_____, 19____

Filed 192 J. F. Walker Registrar.

Registrar.

ALSO BY ALEXANDER

PLACE OF BIRTH

RECEIVED AUG 20 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of BenewahCity of ElwistonNo. St. Joseph St.Registration District No. 96File No. 144315Hospital St. JosephPrimary Registration District No. 1009

Registered No.

FULL NAME OF CHILD

Still Born Susan

(Certificate of no value without full name of child.)

Sex of Child

M.Twin
Triplet
or other?X andNumber
in order
of birthX

(To be answered only in event of plural births)

Legiti-
mate?YesDate of
birthJuly 19, 1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Ag NO3 2%

Number of child of this mother, including present birth

1

Number of child of this mother now living, including present birth

1FULL
NAME

FATHER

John A. StewardFULL
MAIDEN
NAME

MOTHER

Elizabeth Turner

RESIDENCE

Elwiston Ida

RESIDENCE

Elwiston Ida

COLOR

W.AGE AT LAST
BIRTHDAY21

(Years)

COLOR

W.AGE AT LAST
BIRTHDAY21

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Utah

OCCUPATION

laborer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was...
on the date above stated.Born 12 45 P.M.
(Born alive or stillborn)*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Physician
(Physician or midwife)

Give names added from a supplemental report.

....., 19.....

Registrar.

Address

Filed Aug 17, 1926Susan E Bruce
Registrar.

CERTIFICATE OF BIRTH

Registered No. _____

Primary Registration District _____

Child's Name _____

Sex _____

Date of Birth _____

Place of Birth _____

Age at Last Birthday _____

Place of Birth _____

Occupation _____

Registration District No. _____

Primary Registration District _____

Child's Name _____

Sex _____

Date of Birth _____

Place of Birth _____

Age at Last Birthday _____

Place of Birth _____

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OF MOTHER

Signature _____

Address _____

CERTIFICATE OF ATTENDING PHYSICIAN OF CHILD

Signature _____

Address _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 20 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 54575

PLACE OF DEATH

County of Boyer
City of Leoviston

CERTIFICATE OF DEATH

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Born Baby Steward

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of Still Born
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Still Born Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Still Born
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Leoviston Idaho
(State or country)

10 NAME OF FATHER John A Steward

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Betty Garrick

13 BIRTHPLACE OF MOTHER (city or town) Utah
(State or country)

14 Informant John A. Steward
(Address)

15 Filed Aug 18, 1926 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1926, to July 20, 1926, that I last saw him alive on July 20, 1926, and that death occurred, on the date stated above, at 57 m.

The CAUSE OF DEATH* was as follows:
Respiratory Distress
Stillborn
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Stillborn
(Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted ✓
if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) J. H. Steward M. P.
7/22, 1926 (Address) Leoviston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Normal Hill Cemetery Date of Burial 19
20 Undertaker Vassar Undertaking & Leoviston Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

818-14-038-754
PLACE OF BIRTH

County of Payette RECEIVED SEP 7 1926 DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of Payette

No. Cos 10th St. & 6th Ave. N. St.

Registration District No. 4

State File No. 144355

Hospital

Primary Registration District No. 1008

Local Registrar's No. 54

FULL NAME OF CHILD

Baby Hayes (Walbur Fred)

(Certificate of no value without full name of child)

Sex of Child

male

☒ Twin
☐ Triplet
or other

and

Number
in order
of birth

1

Legiti-
mate?

yes

Date of
birth

Aug 14 1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Argrol. Stillborn

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

1

FULL
NAME

FATHER

Lebert Hayes

RESIDENCE

Cos 10th St. & 6th Ave. N.

COLOR

W.

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

Midvale Idaho

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Emmie Pemberton

RESIDENCE

Cos 10th St. & 6th Ave. N.

COLOR

W.

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

Saint Louis Ark.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

☒ Born alive

☐ Stillborn

at

12th 9th

M.

(Signature)

Marcell G. Fox M.D.

(Physician or midwife)

Address

Payette Idaho

Filed

Aug 18 1926

Registrar.

Registrar.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

938

(11) It is suggested that in order to ensure that the

(CUB) - (ALBION)

Johnston
Johnston

78-202
15634

...of this ...

WLTGM

1998

SECRET

SECRET
BIRMINGHAM

●

AGE AT DEATH

1992

13 Aug 1952

5017-108-0000

DECLASSIFICATION OF ATTORNEY-CLIENT OR MEDICAL

~~CONFIDENTIAL~~

(b)(7)(C), (b)(7)(D)

(All copies to be destroyed)

SECRET TO SUE

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Payette
City of PayetteRegistration District No. 4Primary Registration District No. 1008

(No. _____ St.)

State File No. 54594Local Registrar's No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Welber Fred Hayes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male White single
(Write the word)

6. DATE OF BIRTH

Aug 14 1926
(Month) (Day) (Year)

7. AGE

stillbornIF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).laborer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

Gilbert Geo. Hayes

11. BIRTHPLACE

OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME

OF MOTHER

Lucille Pemberton

13. BIRTHPLACE

OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gilbert George Hayes

(Address)

Payette Idaho

15.

Filed

Aug 14 1926 J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 14 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 14 1926 to Aug 14 1926that I last saw him alive on stillborn 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Marion T. Fox M. D.
Payette Idaho

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days, State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mamie's Creek, Ida Aug 14 1926

20. UNDERTAKER

ADDRESS

Glenn C Landon Payette Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

699-113-282-113
PLACE OF BIRTH

RECEIVED SEP 8 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
144428

CERTIFICATE OF BIRTH

County of
City of
No. St. Registration District No. 34 State File No.
Hospital Primary Registration District No. 2087 Local Registrar's No.
FULL NAME OF CHILD Still born
(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? } and { Number in order of birth } Legitimate? yes Date of birth 8 - 13 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME H. W. Wright
RESIDENCE Buhl
COLOR W. AGE AT LAST BIRTHDAY 39
(Years)
BIRTHPLACE Mo.
OCCUPATION Book keeper

MOTHER
FULL MAIDEN NAME Angeline Jackson
RESIDENCE Buhl
COLOR W. AGE AT LAST BIRTHDAY 39
(Years)
BIRTHPLACE Mo.
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2.10 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
....., 192.....

(Signature)

A. J. H. H. H.
Physician or midwife

Address

Buhl, Ida
Filed 9-1 1926
J. H. H. H.
Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. ^{REVISED 1-13}
1. PLACE OF DEATH SEP 8 1926
County of Burke Registration District No. 39
City of Burke Primary Registration District No. 2087
(No. St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Stell Barn

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 54625
Local Registrar's No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS
3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)
6. DATE OF BIRTH _____
(Month) (Day) (Year)
7. AGE _____
IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.
8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____
9. BIRTHPLACE Burke Ia.
(State or Country)
10. NAME OF FATHER A. W. Wright
11. BIRTHPLACE OF FATHER Missouri
(State or Country)
12. MAIDEN NAME OF MOTHER Angeline Jackson
13. BIRTHPLACE OF MOTHER Missouri
(State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. W. Wright
(Address) Burke Ia.
15. _____

MEDICAL CERTIFICATE OF DEATH 189-6
16. DATE OF DEATH Aug 13 1926
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1926 to Aug 13 1926,
that I last saw him alive on Aug 13 1926,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Still born
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) Excessive tension
(Signed) D. F. Fredenburg D.
8/13/26 (Address) Burke Ia.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____
19. PLACE OF BURIAL OR REMOVAL Burke Ia. DATE OF BURIAL 8/13 1926
20. UNDERTAKER D. Johnson ADDRESS Burke

Filed 8-13 1926 J. H. Murphy Local Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)**. For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

141-12800-266
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

SWPR

County of Ada RECEIVED
City of Boise OCT 6 1
No. 6th + Garden Registration District No. 8 State File No. 144512
Hospital _____ Primary Registration District No. 2008 Local Registrar's No. 62

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth Sept. 28 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 1% Silver Nitrate Sol.

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Glen Adamson
RESIDENCE R.D. #2 - Boise Idaho
COLOR White AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Nebraska
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Esther Clute Bowen
RESIDENCE R.D. #2 - Boise Idaho
COLOR White AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Kansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 2:30 A. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 1926

(Signature) T. D. Braxton M. D.
Physician
(Physician or midwife)

Address Boise Idaho
Filed Sept 28 1926

Registrar.

Registrar.

*When there was no attending physician
on duty at the time of the shooting,
an ambulance was sent to take the victim
to the hospital. The ambulance arrived
at 10:15 p.m. and the patient was taken
to the emergency room of the state hospital.
The patient was taken to the emergency room
of the state hospital.

END

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Ada*
City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *8*
Primary Registration District No. *2008*
(No. _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *54671*
Registered No. *53*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept. 28 19*26*
(Month) (Day) (Year)

7. AGE

Still-born
Yrs. Mos. ds.If LESS than 1 day
how many hrs.
or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

Glen Adamson

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Esther Cleo Bowen

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Wm. Adamson

(Address)

Boise R. 2

15.

Filed

Sept. 28 19*26**R. H. Pray*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 28 19*26*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 28 19*26*, to *Sept 28* 19*26*that I last saw him *Still-born* *about 3 days before* and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature detachment of Placenta (probably)(Duration) Yrs. mos. *3* ds.

Contributory (Secondary)

asphyxiation(Duration) yrs. mos. *3* ds.

(Signed)

J. W. Braxton M. D.*Sept 28* 19*26* (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Boise R. 2

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moms Hill Cem. Sept 28 19*26*

20. UNDERTAKER

ADDRESS

By Walter Adamson Boise R. 2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

242-126-00/-459
PLACE OF BIRTH
County of Idaho
City of _____
No. _____ St. _____
Hospital _____
Registration District No. _____ State File No. _____
Primary Registration District No. _____ Local Registrar's No. 6
FULL NAME OF CHILD Russell Dale Busing
(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth 8 6 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Silver Nitrate Sol

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>Cervillo Busing</u>	FULL MAIDEN NAME	<u>Hazel M. Mericle</u>
RESIDENCE	<u>Kuna, Idaho</u>	RESIDENCE	<u>Kuna, Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>26</u> (Years)	AGE AT LAST BIRTHDAY	<u>24</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Laborer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 12 - - M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) _____

Address _____

Filed 9-30 1926

Registrar.

Registrar.

CERTIFICATE OF BIRTH

Registration District No. _____
 Local Board No. _____
 Date of Birth _____
 (Month) (Day) (Year)

Place of Birth _____
 Date of Birth _____
 (Month) (Day) (Year)

Number of child of this mother now living including present birth _____

MOTHER

FULL
NAME

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

AGE AT LAST

BIRTHDAY

COLOR

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was _____
 Date _____

(Signature)

I hereby certify that I attended the birth of this child who was _____
 Date _____

Address

102

Filed

102

RECEIVED SEP 8 1936

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

54374

State File No.

PLACE OF DEATH

County of Ada

Registration District No.

City of Rural

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Russell D. Busing(a) Residence. 3 3/4 miles W. of St.

(Usual place of abode)

Length of residence 1 year or longer occurred Idaho da. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ada, Ida.10 NAME OF FATHER Civil Busing11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine12 MAIDEN NAME OF MOTHER Angie Mericle13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant (Address)

15 Filed 8-14, 1936 Roy Musselmann Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 6 1936
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 1936, to Aug 7, 1936.that I saw h. alive on Aug 6, 1936.and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH was as follows:

Still Born caused
by disease of umbilical
cord
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Coleman M. D.8-7-, 1936 (Address) Rural, Ada

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Kearney Cemetery Aug 7 1936

20 Undertaker Address

H. R. Robinson Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

915-206-003-289
PLACE OF BIRTH

RECEIVED OCT 15 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonanza
City of Parashels

CERTIFICATE OF BIRTH

144628

No. _____ St. _____ Registration District No. 28 State File No. _____

Hospital _____ Primary Registration District No. 2161 Local Registrar's No. 7798

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>Yes</u>	Date of birth <u>Sept 6 - 1926</u>
(To be answered only in event of plural births)			(Month) (Day) (Year)	

What bactericidal solution was used in eyes? None for

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Andrew P. Ransom
RESIDENCE Parashels
COLOR White AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Utah
OCCUPATION P. F. E. Engineer

MOTHER
FULL MAIDEN NAME Heda Byington
RESIDENCE Parashels
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 192_____

(Signature) [Signature]
(Physician or midwife)

Address Parashels

Filed 9/1 1926 [Signature] Registrar.

Registrar.

Exact statement of OC-
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 54683

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28

Primary Registration District No. 2-1-4

Local Registrar's No. 4785

(No. of residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Rantstrom

(a) Residence. No. 257-4 3rd St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 8-1926

7 AGE Years Months Days 1 If LESS than 1 day, hrs. or min. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pocatello
(State or country) Idaho.

10 NAME OF FATHER A.P. Rantstrom

11 BIRTHPLACE OF FATHER (city or town) Utah
(State or country)

12 MAIDEN NAME OF MOTHER Vida Byington

13 BIRTHPLACE OF MOTHER (city or town) Idaho.
(State or country)

14 Informant A.P. Rantstrom
(Address) Pocatello

15 Filed 9-9, 1926

Registrar J. H. Young

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 8 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Stillborn.
Probably Died 3 Days
Before Birth
(duration) yrs. mos. ds.
CONTRIBUTORY Pneumonia
(Secondarily) Pneumonia
(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. H. Young, M. D.
9/10, 1926 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Mountain View Cem Date of Burial Sept 9 1926
20. Undertaker Schunacker & Hall Address Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

693-28-083-613

PLACE OF BIRTH

RECEIVED OCT 15 1906 STATE OF IOWA
DEPARTMENT OF VITAL STATISTICS

Form V. 2 No. 11-C-25m-7-21-19

County of Franklin

CERTIFICATE OF BIRTH

S
144644

City of Des Moines

Registration District No. 40

File No. _____

No. 213 Franklin St.

Primary Registration District No. 2161 Registered No. 7814

Hospital _____

FULL NAME OF CHILD

Still Born

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>Sept 18</u> 19 <u>06</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	----------------------------	---

FATHER
FULL NAME Laron Williams
RESIDENCE 213 Roosevelt
COLOR White AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Hyrum, Utah
OCCUPATION Stock dealer

MOTHER
FULL MAIDEN NAME Lizzie Walker
RESIDENCE 213 Roosevelt
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Haute, Pa.
OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____, at 650 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

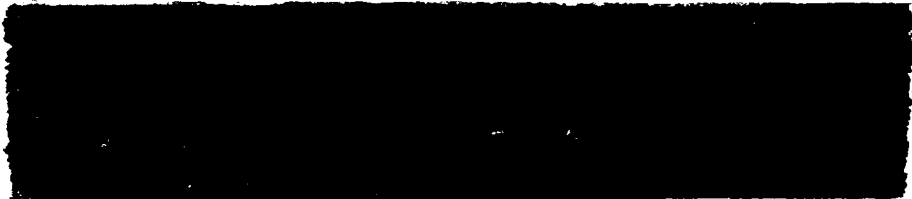
(Signature) Dr. F. Howard, M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address 303-6 Carlton Bldg
Filed 10/1 1906 W. J. Howard Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 10 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **54694**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bernham
City of Pocatello

Registration District No. 28
Primary Registration District No. 2111
(No. Pocatello General Hosp)

Local Registrar's No. 4893

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME True Williams

(a) Residence, No. 213 Rosevelt St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Still born Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pocatello Ida

10 NAME OF FATHER Ben Idaho

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lavon Williams

12 MAIDEN NAME OF MOTHER Elepheth Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant Lavon Williams
(Address) Pocatello, Idaho

15 Filed Sept 20 1926 Registrar McHan

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 18 19 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Stillborn, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 9.2 m.

The CAUSE OF DEATH* was as follows Prolonged labor
(version)
(duration) _____ yrs. _____ mos. 2 ds.

CONTRIBUTORY (Secondary) Version
(duration) _____ yrs. _____ mos. one hr.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? St. J. Haward
(Signed) 9/20, 19 26 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Pocatello, Idaho Date of Burial Sept 20 1926

20. Undertaker McHan Address Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

195-115-004-386
PLACE OF BIRTH

RECEIVED OCT 6 1926

ST. IDAHO
DEPARTMENT OF WELFARE
BUREAU OF STATISTICS

S

County of Bear Lake

City of St Charles

CERTIFICATE OF BIRTH 144689

No. _____ St. Registration District No. 55 State File No. _____

Hospital _____ Primary Registration District No. 2134 Local Registrar's No. 33

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? Yes Date of birth Sept 15 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Alvernis Arnell
RESIDENCE St Charles Idaho
COLOR White AGE AT LAST BIRTHDAY 25
(Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Orelia Ann Thornock
RESIDENCE St Charles Idaho
COLOR White AGE AT LAST BIRTHDAY 20
(Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

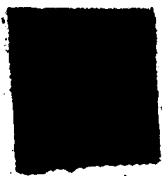
I hereby certify that I attended the birth of this child, who was Stillborn at 8 P M. on the date above stated. Premature, about 6 mos along

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) P. O. Moore M.D.
Paris Idaho
(Physician or midwife)

Give names added from a supplemental report.

Address _____
Filed Sept 17 1926 Effie Wilkes
Registrar. Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERM-
N. B.—In case of more than one child at birth a SEPARATE RETURN
each and the number of each, in order of birth

AGE OF BIRTH RECEIVED SEP 16 1926
219-117-20-556
Barnesville
Idaho Falls
Removal St. Registration District No. 73 State File No.
L.S.S. Primary Registration District No. 2172 Local Registrar's No. 343
NAME OF CHILD Baby Barnes

(Certificate of no value without full name of child)
Sex of Child Male Twin Triplet or other? and { Number in order of birth } Legiti- mate? yes Date of birth Aug 17 1926
(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME William J. Barnes
RESIDENCE St. Anthony
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Idaho Falls
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Thora Newman
RESIDENCE St. Anthony
COLOR white AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Mills Idaho
OCCUPATION W. Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 12 20 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
, 192

(Signature)

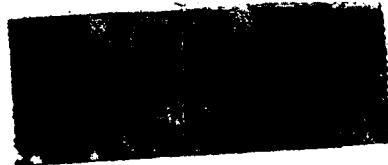
(Physician or midwife)

Address

Filed

Registrar.

Registrar.



FORM V. S. No. 5-25 M. **RECEIVED SEP 16 1926**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **54751**Registered No. **144**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of **Bonner**
City of **Idaho Falls**Registration District No. **73**
Primary Registration District No. **21450**
(No. **21450 Hospital** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

baby
(Write the word.)

6. DATE OF BIRTH

Aug 17 1926
(Month) (Day) (Year)

7. AGE

dead at birth
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho Falls Ida

10. NAME OF FATHER

William J. Barnes

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Thora Newman

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

William J. Barnes
St Anthony, Ida

15.

Filed

Aug 17 1926**Thora Newman**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 17 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 17 1926 to Aug 17 1926
that I last saw him **alive** on **death** **1926**
and that death occurred on the date stated above, at **12:30 A.M.**

The CAUSE OF DEATH* was as follows:

Premature separation of Placenta
in utero **Full Term**
(Duration) Yrs. Mos. ds.Contributory
(Secondary)

(Duration) Yrs. Mos. ds.

(Signed)

M. D.

9/17/26 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. Mos. days. In the State Yrs. Mos. days

Where was disease contracted if not at place of death?

Former or usual residence

St Anthony Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls Ida**Aug 17 1926**

20. UNDERTAKER

ADDRESS

name

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

8-19-2022-010-785
PLACE OF BIRTH RECEIVED SEP 16 1926 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Bonneville
City of Idaho Falls
No. Memorial St. Registration District No. 73 State File No. _____
Hospital L.H.S. Primary Registration District No. 2142 Local Registrar's No. 935

CERTIFICATE OF BIRTH **144806**

FULL NAME OF CHILD Baby Harris
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>1</u>	and { Number in order of birth <u>1</u> }	Legitimate? <u>yes</u>	Date of birth <u>Aug 7</u> 192 <u>6</u> (Month) (Day) (Year)
----------------------------	---------------------------------	---	------------------------	---

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth <u>6</u>		Number of child of this mother now living, including present birth <u>4</u>	
FATHER		MOTHER	
FULL NAME <u>August Augustus Harris</u>	FULL MAIDEN NAME <u>Sadie Mae Green</u>		
RESIDENCE <u>410 9th Street</u>	RESIDENCE <u>110 9th Street</u>		
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>White</u>	AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Iowa</u>	BIRTHPLACE <u>Iowa</u>		
OCCUPATION <u>Salesman</u>	OCCUPATION <u>H. wife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 9305 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) [Signature]
(Physician or midwife)
Address Idaho Falls
Filed 8/14 1926 [Signature]
Registrar.

There was no law enforcement agency in the area at the time of the murder. The nearest law enforcement agency was the Sheriff's Office in the town of...

(Sikpaw)

229766A

Page 18

10. I am not a member of any organization, club, or association, and I am not a member of any political party.

RECEIVED 10 MAR 1964

MOI TA-CHING

2024-10-10

COLOR

2024/12/13 01:32:59

THE

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10-10-68

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WASH 7 8 19

SECRET

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 1-15-16 RECEIVED SEP 16 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonanza
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21, 22
(No. _____ St.)

State File No. 54755
Local Registrar's No. 140

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE & SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

5. DATE OF BIRTH

August 7 1926
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many 0 hrs. or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho Falls

10. NAME OF FATHER

August A. Harris

11. BIRTHPLACE OF FATHER

(State or Country) Fremont Co. Id.

12. MAIDEN NAME OF MOTHER

Sadie M. Green

13. BIRTHPLACE OF MOTHER

(State or Country) Fremont Co. Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) August A. Harris
(Address) 110 - 9 St.

15.

Filed 8/10 1926 Comp Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 7 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19__ to 19__, that I last saw her alive on 19__, and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Stillborn 7 mos.

(Duration) yrs. mos. ds. Contributory (Secondary) Placenta previa Magnesia

(Signed) W. F. McFar M. D. 19__ (Address) Idaho Falls Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the At place In the At place In the At place In the At place In the
of death yrs. mos. days. State yrs. mos. ds. of death yrs. mos. days. State yrs. mos. ds. of death yrs. mos. days. State yrs. mos. ds. of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted if not at place of death? ✓
Former or usual residence ✓

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls Idaho Aug 10 - 1926

20. UNDERTAKER

W. F. McFar Idaho Falls Idaho

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. ~~Always qualify as~~ **"PUERPERAL septicemia," "PUERPERAL peritonitis,"** etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

764 207,010-555
PLACE OF BIRTH

RECEIVED SEP 16 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

144807

County of Blaine
City of Idaho Falls

CERTIFICATE OF BIRTH

No. Memorial Registration District No. 73 State File No. 2115
Hospital L. H. S. Primary Registration District No. 115 Local Registrar's No. 337

FULL NAME OF CHILD Baby Gourley
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other 1 and { Number in order of birth 1 } Legitimate? yes Date of birth Aug. 7 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 2070 Argysol

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME William Gourley
RESIDENCE 128 15th Street S.
COLOR White AGE AT LAST BIRTHDAY 34 (Years)
BIRTHPLACE Valenski Iowa
OCCUPATION Auto mechanic

MOTHER
FULL MAIDEN NAME Myrtle E. Perett
RESIDENCE 128 15th Street
COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Idaho Falls Ida.
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 7 35 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]
(Physician or midwife)

Address Idaho Falls Ida.

Filed 9/17 1926 [Signature] Registrar.

Registrar.

Registrar.

2

OFFICE OF THE
SHERIFF OF THE
COUNTY OF ALTA

REGISTRATION DISTRICT NO. _____
LOCAL HEALTH DISTRICT NO. _____

NAME OF CHILD _____
(Registration of no value without full name of child)

DATE OF BIRTH _____
(Month) (Day) (Year)

SEX OF CHILD _____
(To be removed only in event of female birth)

PLACE OF BIRTH _____
(To be removed only in event of female birth)

NAME OF MOTHER _____
FULL NAME
MOTHER

RESIDENCE _____
COLOR _____
BIRTHPLACE _____
OCCUPATION _____

NAME OF FATHER _____
FULL NAME
FATHER

RESIDENCE _____
COLOR _____
BIRTHPLACE _____
OCCUPATION _____

DATE OF BIRTH _____
(Month) (Day) (Year)

NAME OF CHILD _____
FULL NAME
MOTHER

RESIDENCE _____
COLOR _____
BIRTHPLACE _____
OCCUPATION _____

STATEMENT OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
(Name of child)

(Signature) _____

Address _____

Filed _____

18: _____

(Signature of physician)

When there was an attending physician or midwife, the child's birth should be recorded in one of the following ways: 1. If the mother was a resident of the county, the birth should be recorded in the county records. 2. If the mother was a non-resident of the county, the birth should be recorded in the county records and the county records should be forwarded to the state records.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. N. **RECEIVED SEP 16 1926**

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Country of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 218
(No. _____ St.)

State File No. **54756**
Local Registrar's No. 137

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Gourley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single
(Write the word)

6. DATE OF BIRTH

Aug 7 1926
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many
0 hrs. or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

Wm Gourley

11. BIRTHPLACE OF FATHER

(State or Country)

Wilkesa Iowa

12. MAIDEN NAME OF MOTHER

Myrtle M Covert

13. BIRTHPLACE OF MOTHER

(State or Country)

Columbia Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm Gourley
115 - 15 St.

15.

Filed 9/10

1926

Amund
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 7 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
..... 19..... to 19.....

that I last saw him alive on 19.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn - Full term

Contributory
(Secondary)

(Duration) Prolapsus Cord yrs. mos. ds.

(Signed)

(Duration) W. D. yrs. mos. ds.

19.....

(Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted if not at place of death? 0

Former or usual residence 0

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill Cemetery Aug 8 1926

20. UNDERTAKER

ADDRESS

W. F. M. Han Idaho Falls Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

25-122-011-962
PLACE OF BIRTH RECEIVED OCT 4 1926 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S

County of Boundary
City of Bonners Ferry
No. _____ St. _____ Registration District No. 74 State File No. 144912
Hospital Bonners Ferry Primary Registration District No. 2156 Local Registrar's No. _____
FULL NAME OF CHILD Samuel Eldon Stephenson (decd)
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? ✓ and { Number in order of birth ✓ Legiti- mate? yes. Date of birth Aug. 22 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 1% 64703

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Samuel Walter Stephenson</u>	<u>Bonners Ferry, Ida.</u>	<u>Label Robinson</u>	<u>Bonners Ferry, Ida.</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>17</u> (Years)
BIRTHPLACE <u>Mo.</u>		BIRTHPLACE <u>Mo.</u>	
OCCUPATION <u>Farmer.</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

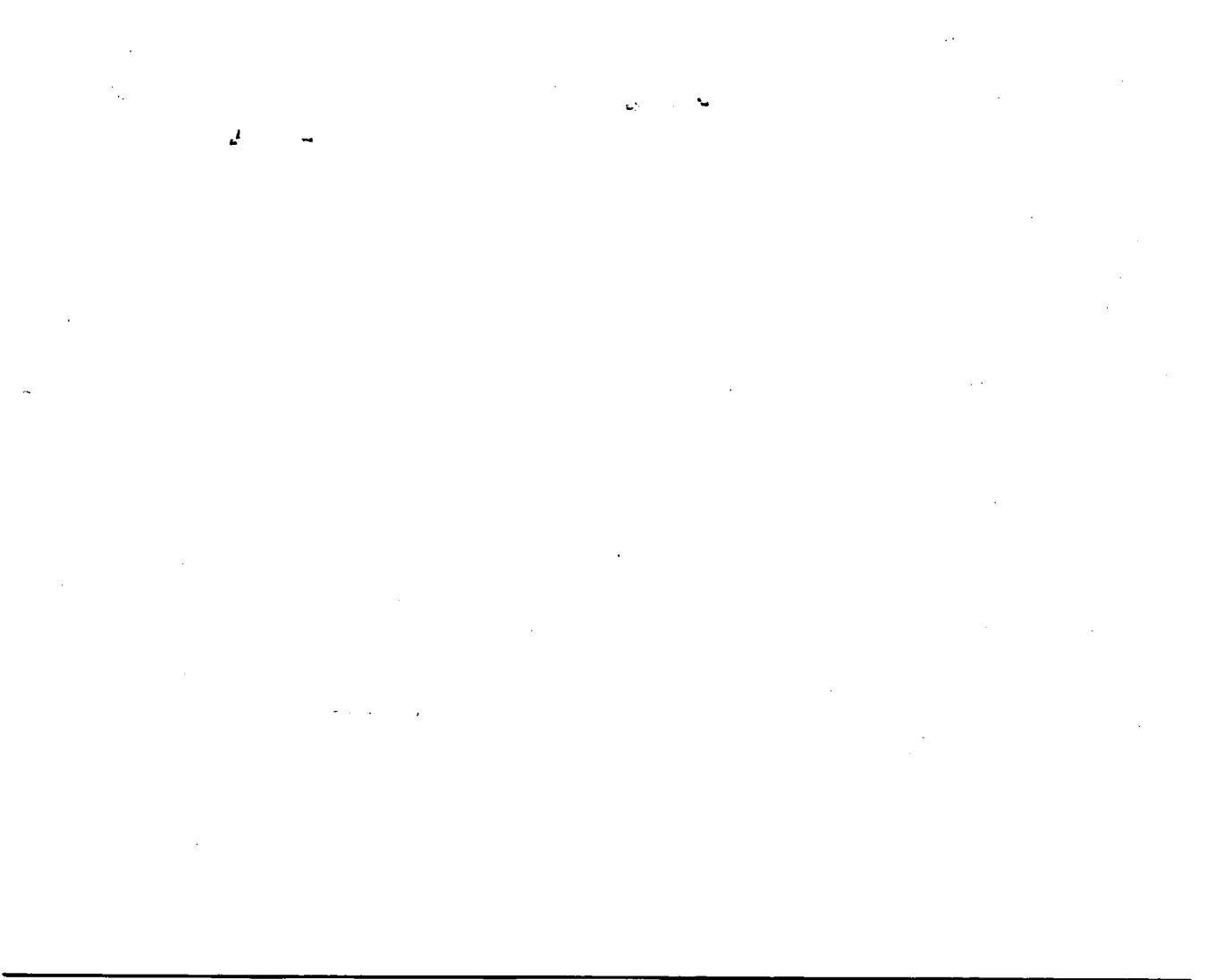
I hereby certify that I attended the birth of this child, who was Stillborn at 8 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1926

(Signature) E. E. Fry
Physician
(Physician or midwife)

Address Bonners Ferry, Ida.
Filed Aug. 23 1926 E. E. Fry
Registrar.



RECEIVED OCT 4 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

PLACE OF DEATH

CERTIFICATE OF DEATH

State File No. 54779

County of Boundary Registration District No. 29

City of Bonnera Ferry Primary Registration District No. 2136 Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Edson Stephenson

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed Aug. 27, 1926

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 19, to , 19,

that I last saw him alive on , 19,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

8/24/1926

(Address)

Bonnera Ferry, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

20. Undertaker

Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

567-228-04-384
PLACE OF BIRTH

RECEIVED SEP 11 1926

County of Canyon

City of Parma

No. St. Registration District No. State File No. 144937

Hospital Primary Registration District No. 2007 Local Registrar's No. 57

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Female	Twin Triplet or other?	and { Number in order of birth	Legiti- mate? yes	Date of birth Aug 28 1926
				(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1		Number of child of this mother now living, including present birth D	
FATHER		MOTHER	
FULL NAME	William Varnen Hopkins	FULL MAIDEN NAME	Cordelia J Cheereh
RESIDENCE	Parma	RESIDENCE	Parma
COLOR	W	COLOR	W
AGE AT LAST BIRTHDAY	20 (Years)	AGE AT LAST BIRTHDAY	21 (Years)
BIRTHPLACE	Washburn Missouri	BIRTHPLACE	Oklahoma
OCCUPATION	Farmer	OCCUPATION	W

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 6:40 A. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

(Physician or midwife)

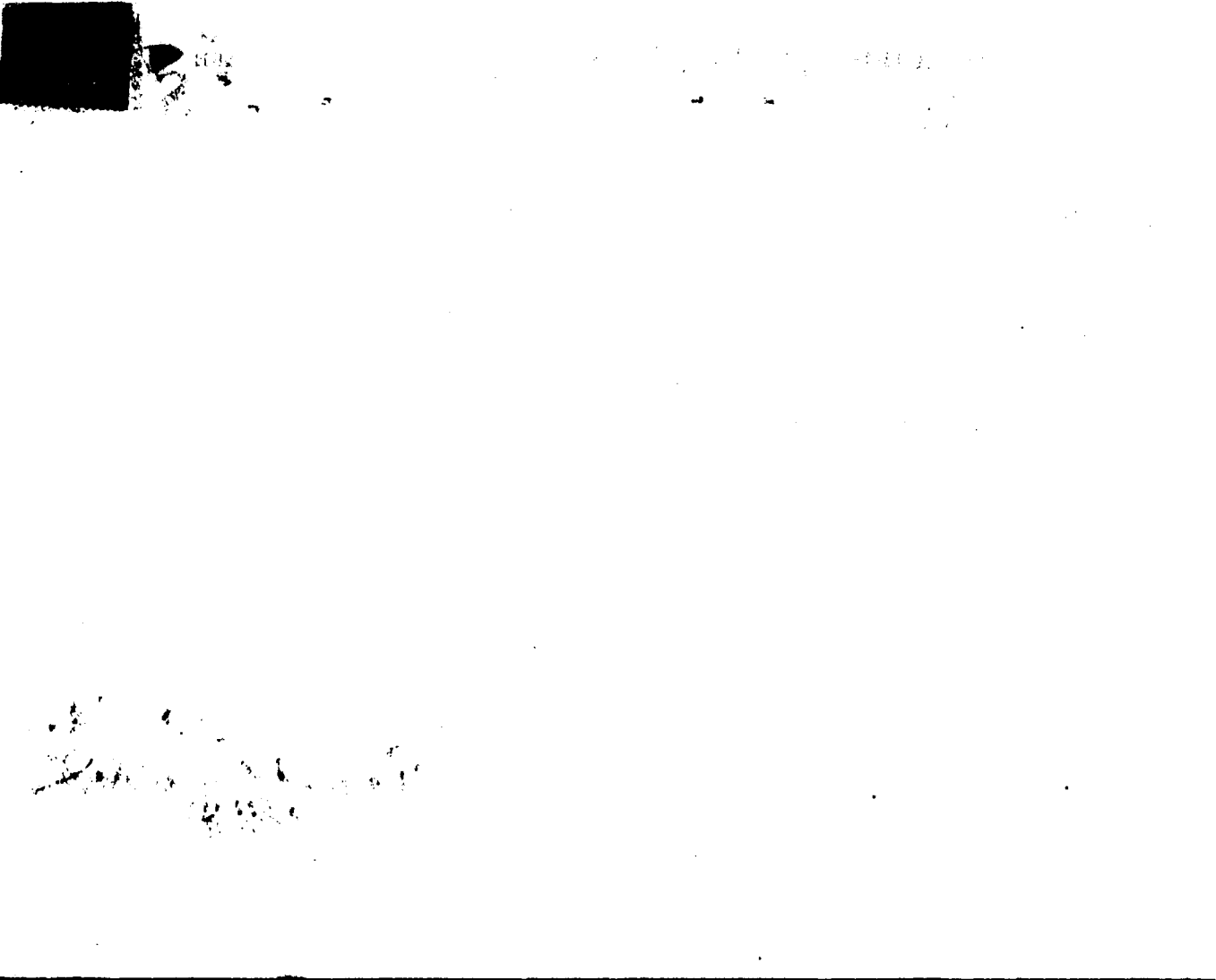
Address

Filed

1926

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 13 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

55177

State File No.

County of

Registration District No.

City of

Primary Registration District No. 2007Local Registrar's No. 9

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Hopkins

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 8-28-1926

7 AGE - Years Months Days
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rowell
(State or country)10 NAME OF FATHER W. V. Hopkins11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mo.12 MAIDEN NAME OF MOTHER Corelia Church13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Okla.

14 Informant A. J. Hopkins
(Address) Rowell

15 Filed Oct 24/26 Paula Waldorf
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

8-28-1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 19....., to Aug 28, 1926

that I last saw him alive on 19.....
and that death occurred, on the date stated above, at birth m.

The CAUSE OF DEATH* was as follows:

Still born.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert E. Tallent M. D.Rowell 1926 (Address) W. S. S. S.

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Rowell 19.....

20. Undertaker

Address

W. S. S. S. Rowell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

619-105-014-667
PLACE OF BIRTH RECEIVED OCT 8 1920

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Canyon
City of Nampa

CERTIFICATE OF BIRTH **144959**

No. St. Registration District No. 7 State File No.
Hospital Primary Registration District No. 1006 Local Registrar's No. 181

FULL NAME OF CHILD James F Ward
(Certificate of no value without full name of child)

Sex of Child Male Twin Triple } and { Number in order of birth } Legitimate? yes Date of birth Aug 5 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Selene

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER	MOTHER
FULL NAME <u>James F Ward</u>	FULL MAIDEN NAME <u>Selma Fozzy</u>
RESIDENCE <u>Nampa</u>	RESIDENCE <u>Nampa</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Long Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Laborer</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 8 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report., 192....

Address Nampa
Filed Oct 4 1926

(Signature) V C Bell
(Physician or midwife)
Mae Herby
Registrar.

000

369-202-014-381

PLACE OF BIRTH

RECEIVED OCT 13 1926

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-22m-2-2-7

S

144976

County of CanyonCity of Caldwell IdaRegistration District No. 3

File No.

No. R.F.W. 1 St.Primary Registration District No. 2005Registered No. 147

Hospital

FULL NAME OF CHILD Sylvia Bell Carney

Sex of Child

FTwin
Triplet
or other?5

and

Number
in order
of birth9Legiti-
mate?yesDate of
Birth10 2 1926
(Month) (Day) (Year)FULL
NAMETheodore Carney

FATHER

FULL
MAIDEN
NAMELulu Charlton

MOTHER

RESIDENCE

Caldwell Ida R1-

RESIDENCE

Caldwell Ida R1

COLOR

WAGE AT LAST
BIRTHDAY40
(Years)

COLOR

WAGE AT LAST
BIRTHDAY38
(Years)

BIRTHPLACE

Colony mo

BIRTHPLACE

Wyconda mo

OCCUPATION

Rancher

OCCUPATION

HousewifeNumber of child of this mother, including present birth 9Number of children of this mother now living, including present birth 8

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 5-9 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

John S. Meyer

Given names added from a supplemental report.

(Physician or midwife)

Address

Caldwell Ida

Filed

10-9-1926

Registrar

John S. Meyer

Registrar

1. *Journal of the American Medical Association*, 1997; 277: 1033-1036.

1. *Journal of the American Medical Association*, 2000; 283: 2689-2694.

1. *Chlorophyll a* and *Chlorophyll b* were determined by the method of Lichtenthaler and Whistler (1972). The *Chlorophyll a* and *Chlorophyll b* contents were expressed as mg/g of fresh weight.

1000

1. 11. 91

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 13 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **54805**Local Registrar's No. **75**

PLACE OF DEATH

County of CanyonCity of Caldwell

CERTIFICATE OF DEATH

Registration District No. 3Primary Registration District No. 2005

(No. _____)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Sylva Bell Carney(a) Residence. No. Route 1 Caldwell Idaho St.

(Usual place of apode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

Stillborn.1 If LESS than
day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

10 NAME OF FATHER

Theo Carney11 BIRTHPLACE OF FATHER (city or town) Knox Cty
(State or country) Missouri

12 MAIDEN NAME OF MOTHER

Lula Charlton13 BIRTHPLACE OF MOTHER (city or town) Knox Cty
(State or country) Missouri14 Informant Theo Carney
(Address) Caldwell Ida Route 115 Filed 10-2-, 1926, John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct21926

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct 2, 1926, to Oct 2, 1926that I last saw her alive on Oct 2, 1926

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

was still born due to
faulty development of skull
was a maturity.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? noWhat test confirmed diagnosis? none

(Signed)

10/4

1926

Address)

Caldwell*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS and NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Canyon Hill

Date of Burial

Oct 2-2619

20. Undertaker

Paul L. Case

Address

Caldwell Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

631-129-
PLACE OF BIRTH

RECEIVED OCT 13 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

144995

County of

City of

No. St. Registration District No. 3 State File No.

Hospital Primary Registration District No. 2007 Local Registrar's No. 720

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>M</u> <u>Undetermined</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Sept 29</u> 192 <u>6</u> (Month) (Day) (Year)
--	---	-------	--------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Yoshio Otani

RESIDENCE Purman R[#] 1

COLOR yellow AGE AT LAST BIRTHDAY 34
(Years)

BIRTHPLACE Japan

OCCUPATION Gardener

MOTHER
FULL MAIDEN NAME Yumiko Yamada

RESIDENCE Purman R[#] 1

COLOR yellow AGE AT LAST BIRTHDAY 26
(Years)

BIRTHPLACE Japan

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. E. Walcott

(Physician or midwife)

Address

Filed

10/10 1926

Kulu Haldy

Registrar.

Registrar.

1

5

4

1

FORM V. S. No. 5-25 M. 1-19.

1.

PLACE

County of

Canyon

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 54812

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male
Under-
termined

4. COLOR OR RACE

Yellow

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word)

6. DATE OF BIRTH

Sept 29 1926
(Month) (Day) (Year)

7. AGE

Still born

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
Father

Yoshio Otani

11. BIRTHPLACE
OF FATHER

(State or Country)

Japan

12. MAIDEN NAME
OF MOTHER

Suzuyo Yamada

13. BIRTHPLACE
OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Yoshio Otani
Parrish, Ida

15.

Filed

10/10

1926

Shulman, Id

Local Registrar

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. About Sept 15-26 1926
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Still born 19 to 19that I last saw h. alive on 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Baby had appearance of
having been dead at birth -
2 weeks - Mother had not
felt life in that time
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. J. Wulch, M. D.

6/2/1926 (Address) Parrish, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parrish Cemetery

Sept. 22 1926

20. UNDERTAKER

ADDRESS

Father buried
infant

Parrish, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **22 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

713-220-016-215

PLACE OF BIRTH

RECEIVED OCT 13 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

145040

County of Cassia

City of Burley

No. _____ St. _____

Registration District No. 117

File No. _____

Hospital Emergency

Primary Registration District No. 2196

Registered No. 3459

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child Female

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

Sept 20 1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? Ag. 100

Number of child of this mother, including present birth 5

Number of child of this mother now living, including present birth 5

FATHER
FULL NAME J. J. Patterson

RESIDENCE Heyburn Ida

COLOR White AGE AT LAST BIRTHDAY 46
(Years)

BIRTHPLACE N. C.

OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ethel Sanders

RESIDENCE Heyburn Ida

COLOR White AGE AT LAST BIRTHDAY 42
(Years)

BIRTHPLACE Arizona

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 3:00 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) H. J. C. Patterson

(Physician or midwife)

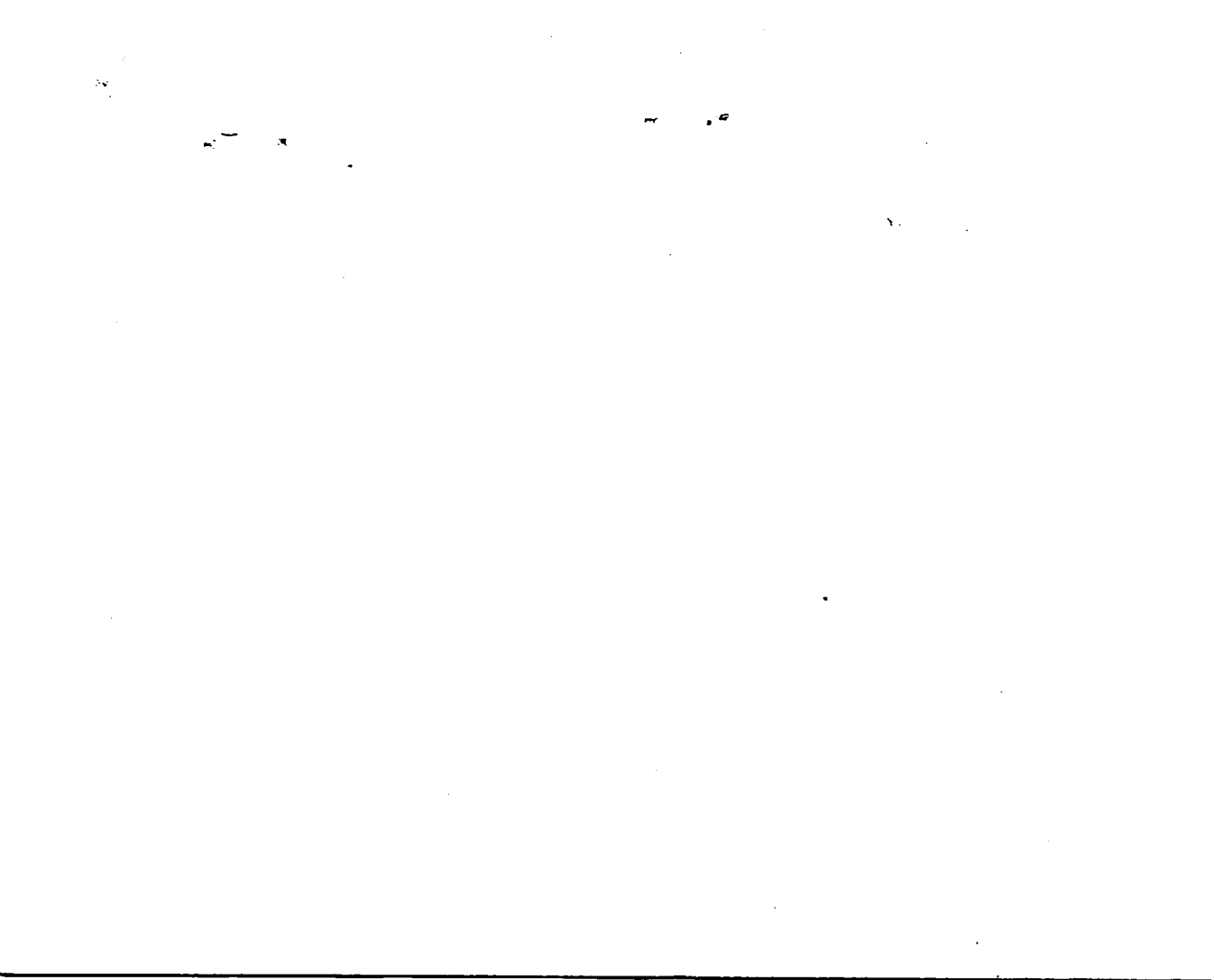
Give names added from a supplemental report.

Address Burley Ida

Filed Oct 1 1926 H. J. C. Patterson

Registrar.

Registrar.



RECEIVED OCT 13 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 54830

PLACE OF DEATH

County of Cassia
City of BurleyRegistration District No. 117Primary Registration District No. 2196Local Registrar's No. 865(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)2. FULL NAME Stillborn(a) Residence. No. Emergency Hospital St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) Sept 20, 19267 AGE Years Months Days
If LESS than
1 day, ____ hrs.
or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Burley Idaho
(State or country)10 NAME OF FATHER J. J. Patterson11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)12 MAIDEN NAME OF MOTHER Ethel Sanders13 BIRTHPLACE OF MOTHER (city or town) Arizona
(State or country)14 Informant J. J. Patterson
(Address) Heyburn, Ida.15 Filed Sept. 21, 1926 Dr. J. C. Patterson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 20 19 26
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,
that I last saw h. _____ alive on _____, 19____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn, cause unknown

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. C. Patterson M. D.Sept. 21, 1926 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Heyburn, Ida. 4-20 1926

20. Undertaker

Address

NoneL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

698-12-02-154
PLACE OF RECEIVED OCT 6 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin
City of Preston

CERTIFICATE OF BIRTH **145123**

No. _____ St. _____ Registration District No. 27 State File No. _____

Hospital _____ Primary Registration District No. 2119 Local Registrar's No. 202

FULL NAME OF CHILD No name

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>L</u>	and {	Number in order of birth <u>3rd child</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Sept 12 - 1926</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FULL NAME <u>William Fryer</u>	FATHER
RESIDENCE <u>Preston Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Dewey Utah</u>	
OCCUPATION <u>R.R. Agent</u>	

FULL MAIDEN NAME <u>Elva Anderson</u>	MOTHER
RESIDENCE	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Logan Utah</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 330 p. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature)

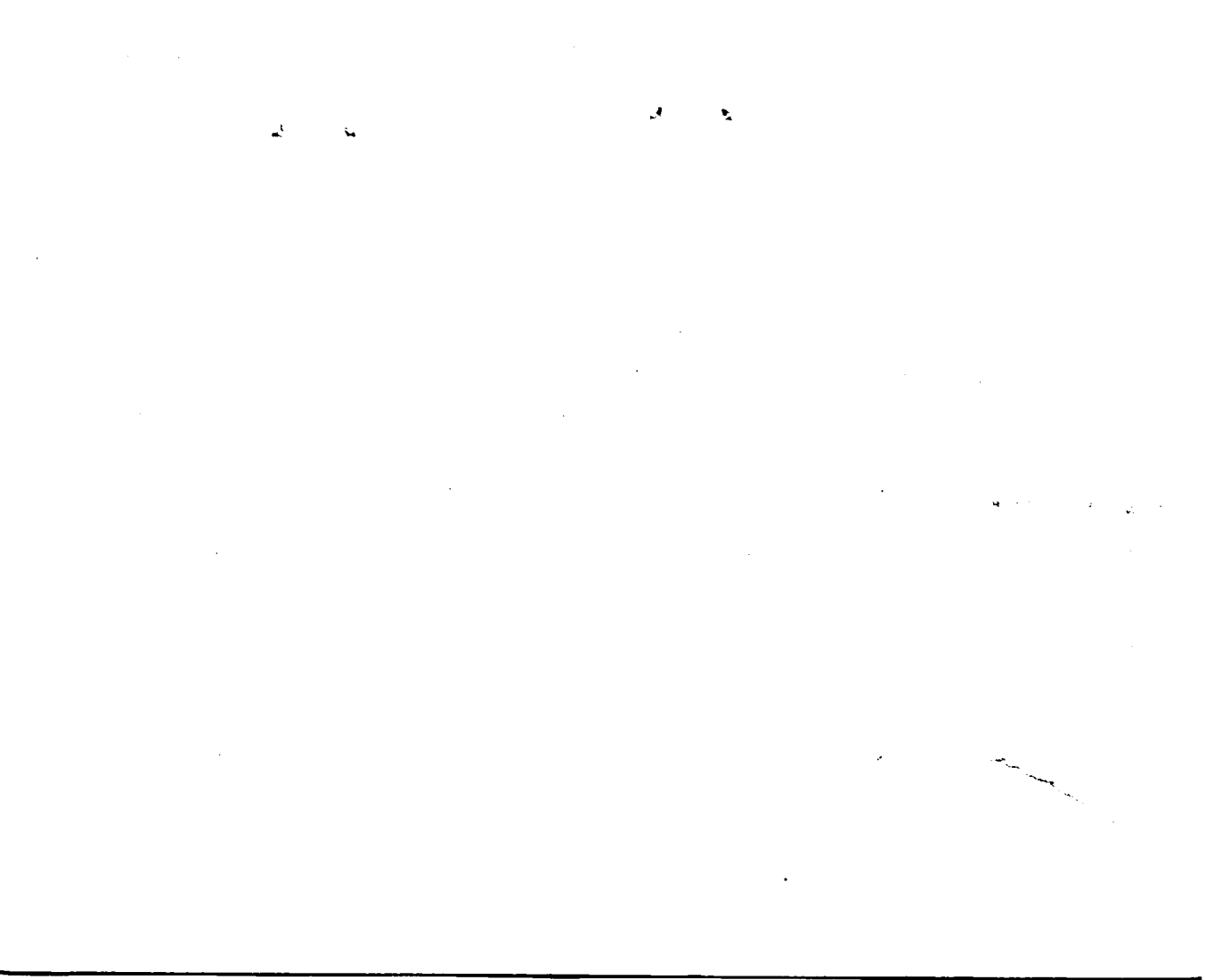
(Physician or midwife)

Address

Filed

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-11

1. PLACE OF DEATH

County of FranklinCity of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 27Primary Registration District No. 2119

(No. _____ St.)

Still bornSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 54855Local Registrar's No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale white Single
(Write the word)

6. DATE OF BIRTH

Sept 12 1926
(Month) (Day) (Year)

7. AGE

Child born deadIF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

William Fayer

11. BIRTHPLACE

OF FATHER

(State or Country)

Utah

12. MAIDEN NAME

OF MOTHER

Elva Anderson

13. BIRTHPLACE

OF MOTHER

(State or Country)

Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. R. Culler
Preston Idaho

15.

Filed

19

Local Registrar

A. R. Culler

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 12 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 12 1926 to Sept 12 1926that I last saw h. never lived 19and that death occurred on the date stated above, at 3:30 p. M.

The CAUSE OF DEATH* was as follows:

Effects of Childbirth -
Placenta previa in mother

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. W. States M. D.
7-1319 24 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Logan Utah

DATE OF BURIAL

Sept 15 1926

20. UNDERTAKER

M. W. Hendricks

ADDRESS

Preston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

693-128-526-513
PLACE OF RECEIVED OCT 15 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Jefferson
City of Rigby
No. _____ St. _____ Registration District No. 98 State File No. 145284
Hospital _____ Primary Registration District No. 2176 Local Registrar's No. 166

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child m Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth Sept 29 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Richard F Wilson</u>	<u>Rigby</u>	<u>Fay Valentine</u>	<u>same</u>
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Clerk</u>		OCCUPATION <u>at home</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1045 A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 192____

(Signature)

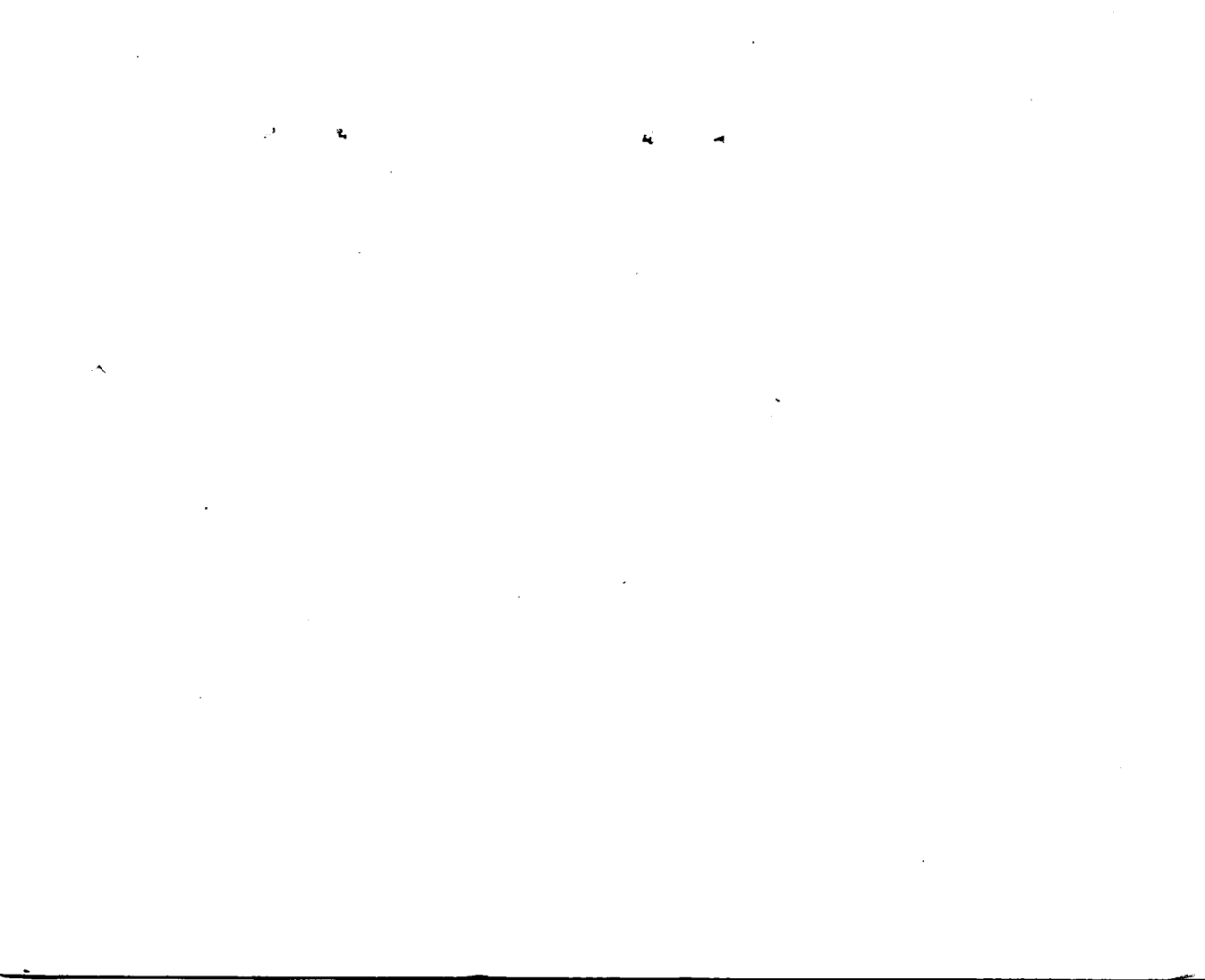
(Physician or midwife)

Address

Filed

Registrar.

Registrar.



FORM V. S. No. 5-25 MAY 1926

RECEIVED OCT 15 1926

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **54883**
Registered No. **60**

1. PLACE OF DEATH

Registration District No. **98**County of **Jefferson**Primary Registration District No. **2176**City of **Rigby**

(No. _____, _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Sept 29 1926
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHER**Richard F. Wilson**11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHER**Jay Valentine**13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. F. Wilson
Rigby, Idaho

15.

Filed

Oct 10 1926
Ray Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 29 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____.

that I last saw him alive on 19____.

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Ray Fisher M. D.

9/30/26 (Address) **Rigby, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rigby

9/30 1926

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

255-160228-239

PLACE OF BIRTH

County of KootenaiCity of Laurel, IdahoNo. 207Laurel, Idaho

St.

Registration District No. 30State File No. 145303Hospital RaidPrimary Registration District No. 1051Local Registrar's No. 1603FULL NAME OF CHILD Edward Donald Severin

(Certificate of no value without full name of child)

Sex of Child BoyTwin
Triplet
or other?

} and {

Number
in order
of birthLegiti-
mate? yesDate of
birth June 16 1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? 9:10 P.M.Number of child of this mother, including present birth 9Number of child of this mother now living, including present birth oneFULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 9:15 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

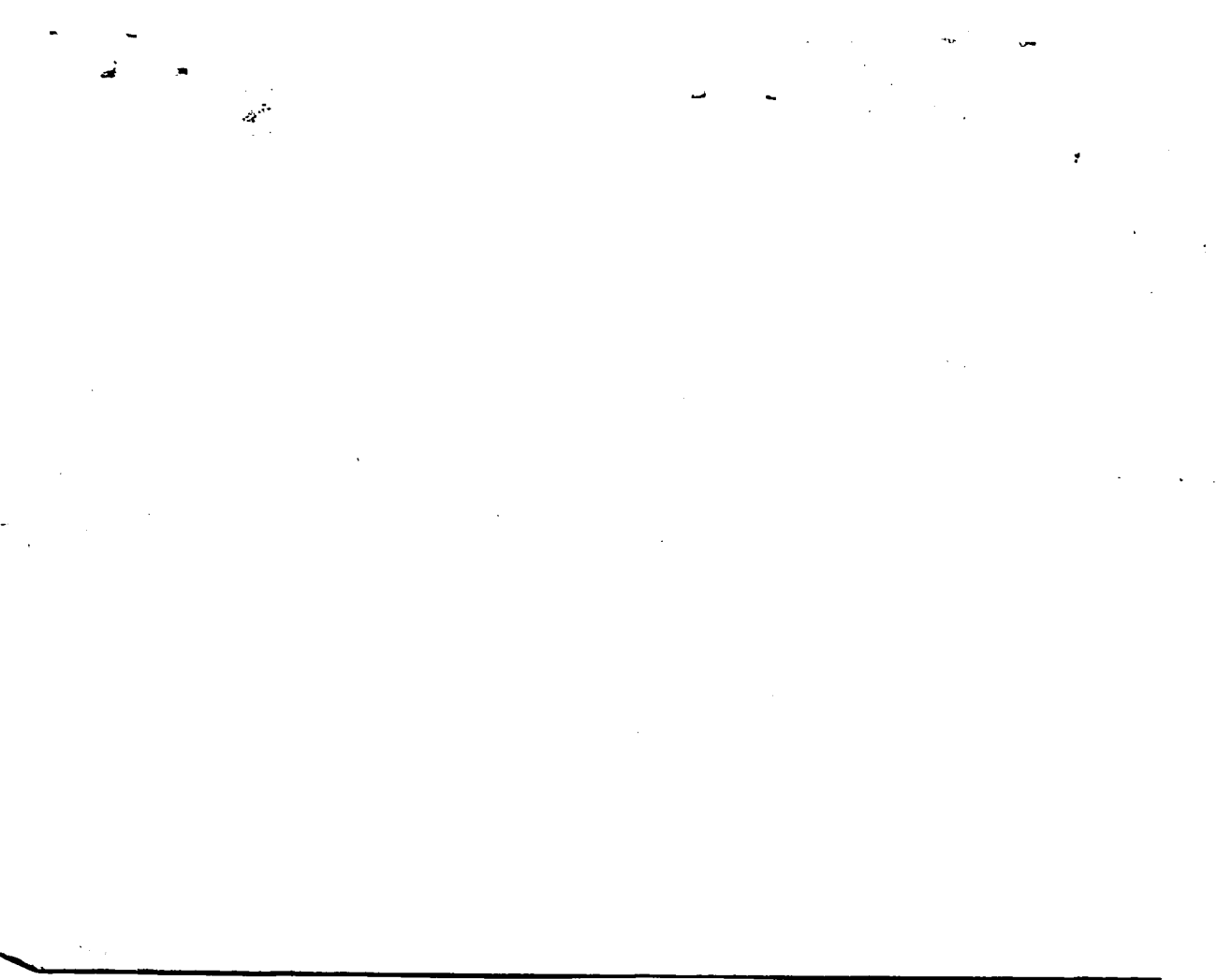
(Signature) J. C. [Signature]

(Physician or midwife)

Address Laurel, IdahoFiled Oct 6 1926

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. **RECEIVED JUL 6 1926** CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 30
 County of Kootenai Primary Registration District No. 1051
 City of Coeur d'Alene (No. 1224, Front— St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Severin

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 53957
 Registered No. 1475

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
 (Write the word.)

6. DATE OF BIRTH 6 - 16 1926
 (Month) (Day) (Year)

7. AGE 0 yrs. 0 mos. 0 ds. IF LESS than 1 day how many 0 hrs. or 0 min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Coeur d'Alene Ida.

10. NAME OF FATHER C. Severin

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Vaulda Strom

13. BIRTHPLACE OF MOTHER (State or Country) Reinlander Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Severin
 (Address) 1224 Front St. Coeur d'Alene

15. Filed June 4 19126 N. L. K. K. K.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 16 1926
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191
 that I last saw h. — alive on — 191
 and that death occurred on the date stated above, at M.
 The CAUSE OF DEATH* was as follows:

Still born -

(Duration) — yrs. — mos. — ds.
 Contributory Placental separation of placenta
 (Secondary)

(Duration) — yrs. — mos. — ds.
 (Signed) J. O. K. M. P.
6/17 1926 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death — yrs. — mos. — ds. State — yrs. — mos. — ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Forest Cem. Coeur d'Alene 6-17 19126

20. UNDERTAKER ADDRESS
Carstedt Coeur d'Alene

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

236-217-028-285
PLACE OF BIRTH

RECEIVED OCT 11 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai

City of at Ross Point

CERTIFICATE OF BIRTH

145323

No. _____ St. _____ Registration District No. 30 State File No. _____

Hospital _____ Primary Registration District No. 1081 Local Registrar's No. 1673

FULL NAME OF CHILD (unnamed) Stotler

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth Sept 17 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Fred Stotler
RESIDENCE Ross point Idaho
COLOR white AGE AT LAST BIRTHDAY 46 (Years)
BIRTHPLACE Missouri
OCCUPATION Barryman

MOTHER
FULL MAIDEN NAME Stella Shepherd
RESIDENCE Ross point
COLOR white AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Michigan
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Levin H. Most

(Physician or midwife)

Address Coeur d'Alene, Idaho

Filed Oct 6 1926 D. D. Drenna

Registrar.

Registrar.

RECEIVED 00111 1926

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of *Kootenai*
City of *Rathdrum*Registration District No. *30*
Primary Registration District No. *1037*
(No. _____ St.)File No. *54897*
Registered No. *1499*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(unnamed) Stotler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) *1*

7. AGE

0 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kootenai County

10. NAME OF FATHER

Fred Stotler

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Stella Shepherd

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Heppie Bailey

(Address)

614 E. 1st St. Idaho

15.

Filed

*Oct-6 19126**H. P. Druce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 17(Month) _____ (Day) _____ (Year) *1926*

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____

that I last saw him _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

*Still-born at 5. pm
Two months previous to birth
of foetus mother was injured
by horse*
(Duration) _____ yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Sept 17 1926 *Lewis H. Most* M. D.
(Address) *Coeur d'Alene Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Rathdrum**9/18 1926*

20. UNDERTAKER

ADDRESS

R. B. Mooney *Shenandoah Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

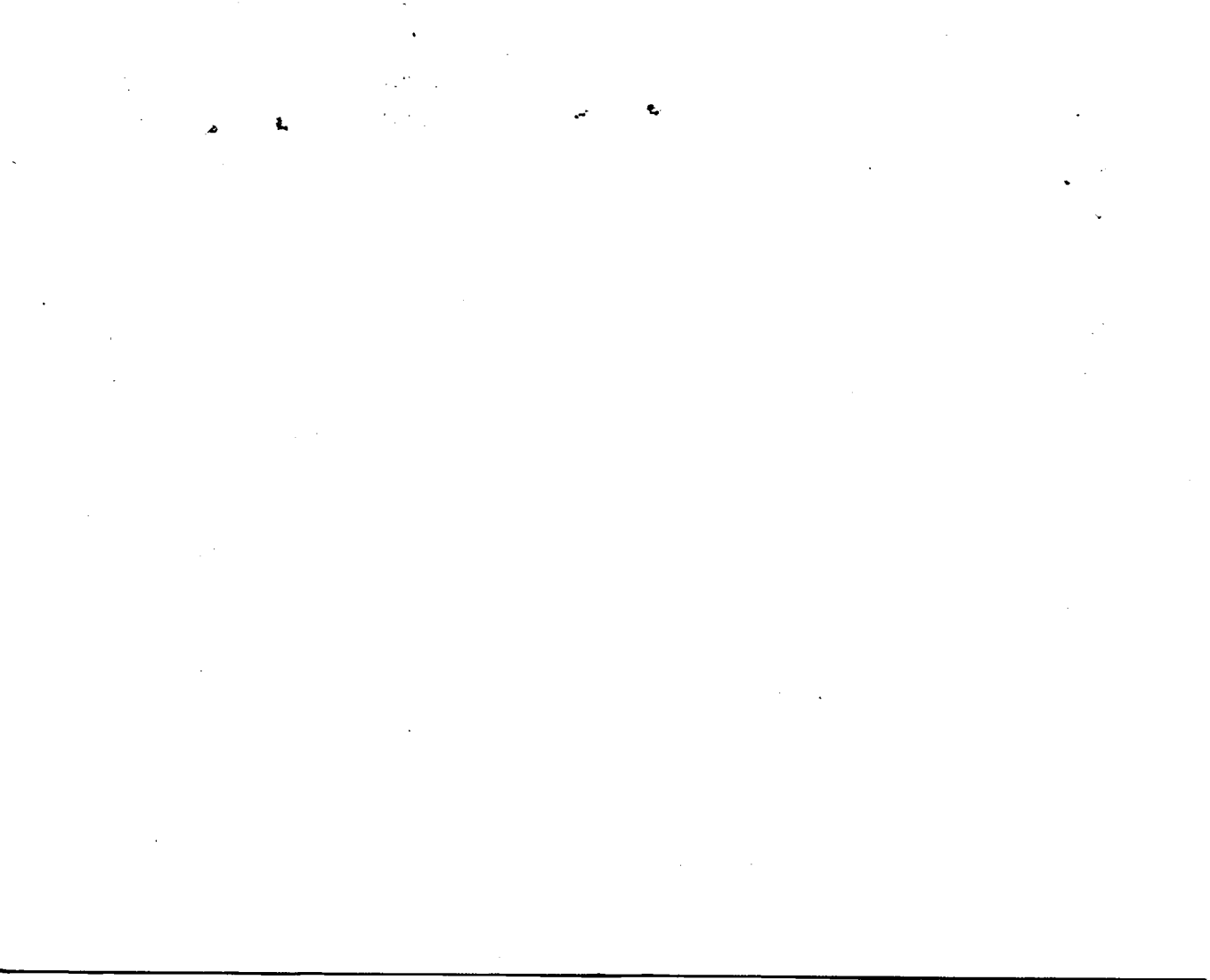
STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital)" "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

142-2251028-347
PLACE OF BIRTH RECEIVED OCT 11 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
COUNTY OF Kootenai
CITY OF Post Falls, Idaho
CERTIFICATE OF BIRTH
No. B. I. D. # 2 St. Registration District No. 30 State File No. 145325
Hospital _____ Primary Registration District No. 1051 Local Registrar's No. 1675
FULL NAME OF CHILD Baby Adkins - (Not named)
(Certificate of no value without full name of child)
Sex of Child Female Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? Yes Date of birth Sept. 25 1926
(To be answered only in event of plural births) (Month) (Day) (Year)
What bactericidal solution was used in eyes? 10% Argysol Sol.
Number of child of this mother, including present birth 12 Number of child of this mother now living, including present birth 11
FULL NAME FATHER Sam B. Adkins FULL NAME MOTHER Emma Huguenin
RESIDENCE Post Falls, Idaho. R. 2d # 2 RESIDENCE Post Falls, Ida. R. 2d # 2
COLOR White AGE AT LAST BIRTHDAY 60 COLOR White AGE AT LAST BIRTHDAY 41
(Years) (Years)
BIRTHPLACE Kansas BIRTHPLACE Idaho
OCCUPATION Farmer OCCUPATION Housewife
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was Stillborn at 10:45 A. M.
on the date above stated.
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 192_____

Registrar. _____
Address _____
Filed Oct 6 1926 D. D. Drama
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 54887
Registered No. 1440
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of *Toole* Registration District No. *30*
City of *Post Falls* Primary Registration District No. *1051*
(No. St.)

2. FULL NAME *(unnamed) Adkins*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)
6. DATE OF BIRTH. *Sept 25th 1926*
(Month) (Day) (Year)
7. AGE *Still-born* IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Post Falls Idaho*
(State or Country)

10. NAME OF FATHER *Sf. Adkins*

11. BIRTHPLACE OF FATHER *Kansas*
(State or Country)

12. MAIDEN NAME OF MOTHER *Emma Huguenin*

13. BIRTHPLACE OF MOTHER *France*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs. S. J. Adkins*
(Address) *Post Falls, Id.*

15. Filed *Oct 6 1926* *D. D. Drenner*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept 25 1926*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191... to 191...
that I last saw h... alive on 191...
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Still-born
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) *F. B. McCauley*
9/26/1926 (Address) *Post Falls, Id.*

*State the Disease Causing Death; or in deaths from Violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. mos. days, State ... yrs. mos. days
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Post Falls* DATE OF BURIAL *9/26 1926*

20. UNDERTAKER *Adkins* ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

243-218102-9-814
PLACE OF BIRTH RECEIVED OCT 7 1926STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS145363 S
145363

CERTIFICATE OF BIRTH

County of Latah
City of Moscow
No. 120 So Main St.
Hospital The EnterpriseRegistration District No. 61 File No. _____
Primary Registration District No. 1011 Registered No. 102

FULL NAME OF CHILD

Baby Butterfield

(Certificate of no value without full name of child.)

Sex of Child Female Twin Triplet or other? and Number in order of birth Legitimate? Yes Date of birth Sept 18 1926
(To be answered only in event of plural births) (Month) (Day) (Year)What bactericidal solution was used in eyes? Argyrol 10%Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2FULL NAME FATHER Polston Samuel ButterfieldFULL MAIDEN NAME MOTHER Lorne HamiltowRESIDENCE Moscow IdahoRESIDENCE Moscow, IdahoCOLOR White AGE AT LAST BIRTHDAY 4.3 (Years)COLOR White AGE AT LAST BIRTHDAY 34 (Years)BIRTHPLACE Hirgcon, Wis.BIRTHPLACE Seattle, Wash.OCCUPATION Insurance SalesmanOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at 8:58 a. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

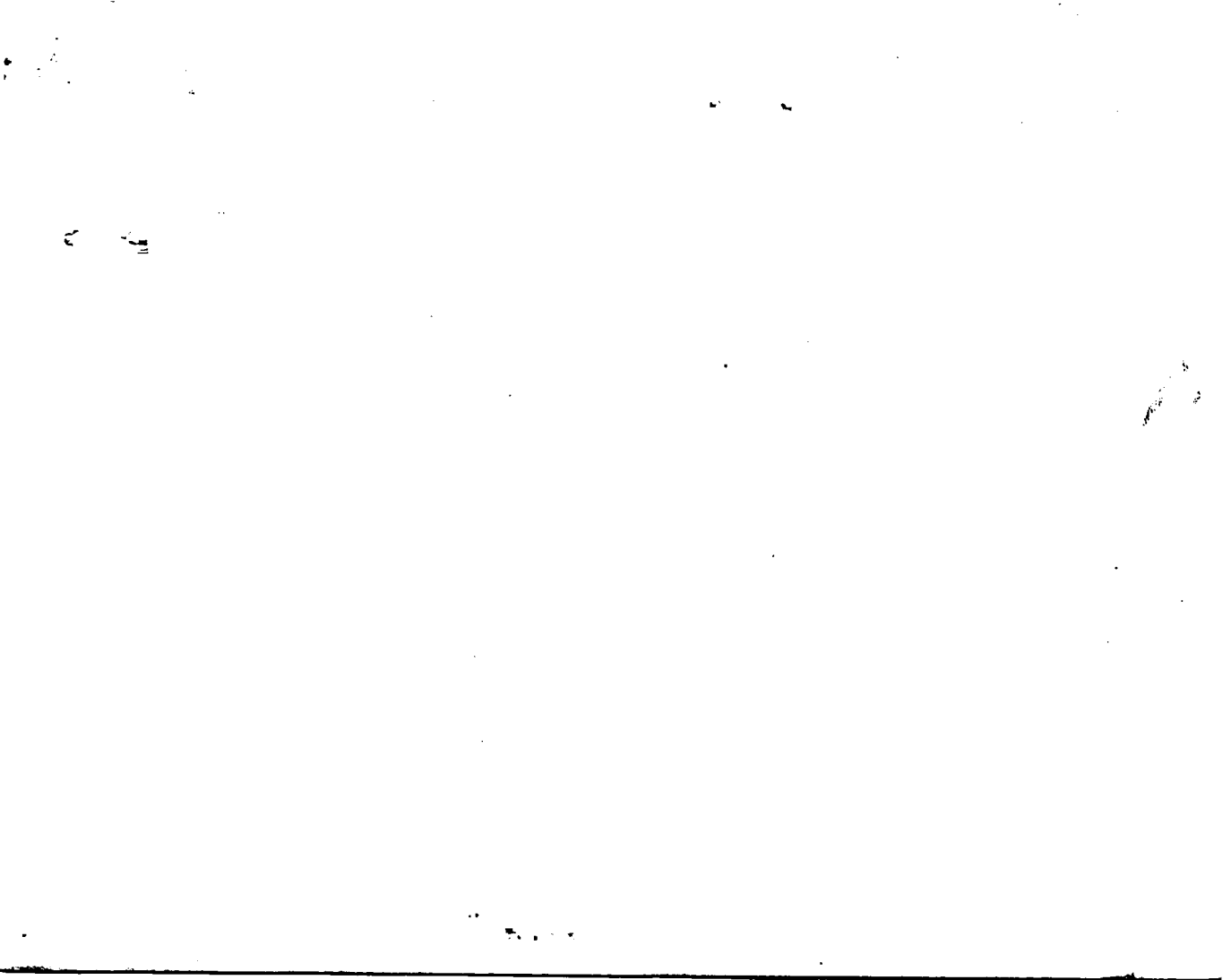
Chas. L. Gutman
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address

Moscow, IdahoFiled Oct. 1 1926W. A. Caruthers
Registrar.

Registrar.



RECEIVED OCT 7 1926

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of LatahCity of MOSCOW

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 601Primary Registration District No. 1041

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 54912Registered No. 56

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Butterfield (Stillborn)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

F

White

Child
(Write the word.)

6. DATE OF BIRTH

Sept. 18 1926
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Moscow, Idaho

10. NAME OF FATHER

Rolston Butterfield

11. BIRTHPLACE OF FATHER

(State or Country) Wis.

12. MAIDEN NAME OF MOTHER

Leone Hamilton

13. BIRTHPLACE OF MOTHER

(State or Country) Wash/

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. S. Butterfield(Address) Moscow, Ida.

15.

Filed 9/18 1926W. H. Carithers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 18, 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at home 19 Sept. 18, 1926

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. J. Ginterman M. D.9/18/26 (Address) Moscow, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

9/18/26 Moscow

DATE OF BURIAL

9/18/26

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

279-101-
651-213 RECEIVED SEP 13 1926
PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-25m-1-1-13

CERTIFICATE OF BIRTH

S

County of Lewis

City of Nezperce Idaho
village

No. _____ St.

Hospital _____

FULL NAME OF CHILD

Registration District No. 47

File No. 145387

Primary Registration District No. _____

Registered No. 289

Springer (no name) Dec 2

Sex of Child Male { Twin Triplet or other? _____ } and { Number in order of birth 4 } Legiti- mate? yes Date of Birth 9-1 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

FULL NAME FATHER Marion Springer
RESIDENCE Nezperce
COLOR White AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE Ohio
OCCUPATION Farmer

FULL MAIDEN NAME MOTHER Ethel Ballard
RESIDENCE Nezperce
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Colorado
OCCUPATION Housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Dead born Hydrocephalus 11 11 11
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr Taylor MD

(Physician or midwife)

Given names added from a supplemental report.

Address Nezperce Idaho

Filed 9-10 1926 Albert Huff Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

866-121-042-289
PLACE OF BIRTH

RECEIVED OCT 13 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S
145656

County of T. F.
City of Buhl
No. _____ St. _____ Registration District No. 39 State File No. _____
Hospital _____ Primary Registration District No. 2087 Local Registrar's No. Howerton
FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>7-21-1926</u> (Month) (Day) (Year)
--------------------------	------------------------------	--------------------------------------	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FULL NAME

FATHER

Perce R. Howerton

RESIDENCE

Buhl

COLOR

wh

AGE AT LAST BIRTHDAY

25
(Years)

BIRTHPLACE

Ind.

OCCUPATION

Laborn (Farm)

FULL MAIDEN NAME

MOTHER

Hattie Squire

RESIDENCE

Buhl

COLOR

wh

AGE AT LAST BIRTHDAY

21
(Years)

BIRTHPLACE

Cal.

OCCUPATION

S.W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 5 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

D. Geo. Jennings

(Physician or midwife)

Address

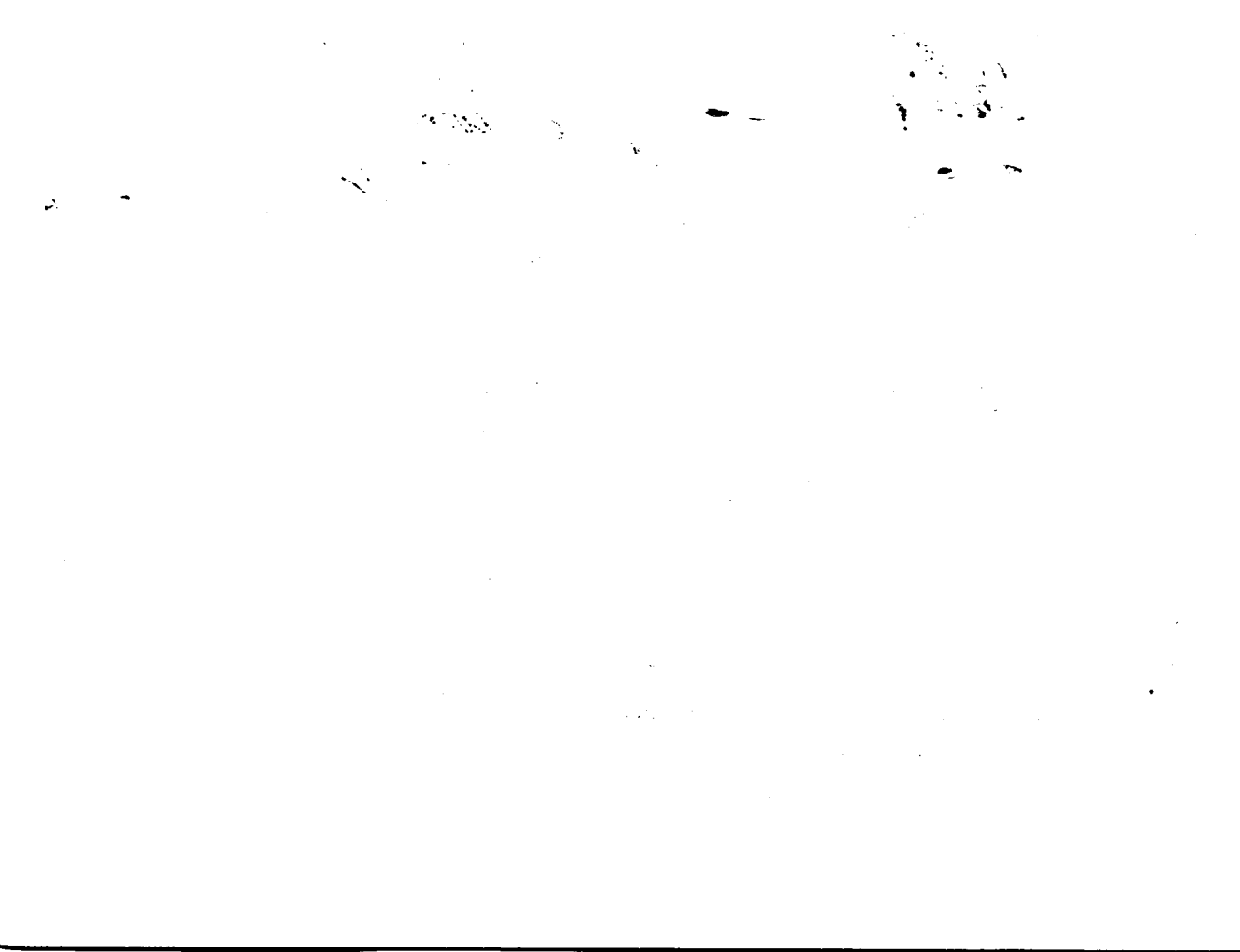
Buhl, Ida.

Filed

SEP 13 1926

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25

RECEIVED AUG 10 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Lincoln*
City of *Castleford*Registration District No. *39*Primary Registration District No. *2087*State File No. *54331*

Local Registrar's No. _____

If death occurs away from *home*
usual residence, give facts *Swad*
called for under special in-
formation. *Radio*

2. FULL NAME

(No. _____ St. _____)

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *Single*

(Write the word)

6. DATE OF BIRTH

July 20 1926
(Month) (Day) (Year)

7. AGE

X Yrs. *X* Mos. *X* ds. *X*IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work. *X*
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

*Castleford, Ida.*10. NAME OF
Father*Pierce Hawerton*11. BIRTHPLACE
OF FATHER

(State or Country)

*Indiana.*12. MAIDEN NAME
OF MOTHER*Nattie Squires*13. BIRTHPLACE
OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Pierce Hawerton

(Address)

Castleford, Ida.

15.

Filed *7-21*

1926

J. H. Murphy

Local Registrar

MEDICAL CERTIFICATE OF DEATH *1846*

16. DATE OF DEATH

7-20-26
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
7-20-26 19*26* to *2-20-26* 19*26*that I last saw him alive on *7-20-26* 19*26*
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stomach

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Pro J. H. Murphy M. D.19*26*(Address) *Bull Id.**State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Bull Id.**July 21 1926*

20. UNDERTAKER

ADDRESS

*L. J. Johnson**Bull Id.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

719-117-

PLACE OF BIRTH

RECEIVED OCT 11 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

145692

County of Washington

City of Wenatchee

No. _____ St. _____

Registration District No. 76

File No. _____

Hospital _____

Primary Registration District No. 1414

Registered No. 13

FULL NAME OF CHILD

Baby Garrett

(Certificate of no value without full name of child.)

Sex of Child

male

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

July 17

1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? no.

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 4

FULL
NAME

FATHER

Harry F. Garrett

RESIDENCE

Wenatchee Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

33

(Years)

BIRTHPLACE

no.

OCCUPATION

Business collector

FULL
MAIDEN
NAME

MOTHER

Mildred G. C. Robertson

RESIDENCE

Wenatchee Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

33

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at _____
on the date above stated.

_____ at _____
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

F. Schmidt

(Physician or midwife)

Give names added from a supplemental report.

Address

Wenatchee Idaho

Filed

Oct 15 1926

Dr. R. H. Havel

Registrar.

Registrar

NUD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

557-213-044
PLACE OF BIRTH
County of Washington
City of Wash
No. 446 Commercial St. Registration District No. 1 State File No. 145701
Hospital Morehead Primary Registration District No. 490 Local Registrar's No. 1
FULL NAME OF CHILD Constitution English

(Certificate of no value with no full name of child.)

Sex of Child Female Twin Triplet or other? and Number in order of birth 1 Legitimate? Yes Date of birth Sept 13, 1921
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

FATHER		MOTHER	
FULL NAME	<u>Arthur English</u>	FULL NAME	<u>Clara De Biaso</u>
RESIDENCE	<u>Long Ave</u>	RESIDENCE	<u>Long Ave</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>28</u> (Years)	AGE AT LAST BIRTHDAY	<u>31</u> (Years)
BIRTHPLACE	<u>Pueblo Colo</u>	BIRTHPLACE	<u>Pueblo Colo</u>
OCCUPATION	<u>Cement Mechanic</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Home-birth at 11 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. M. Kaleshew

(Physician or midwife)

Address Wash D.C.

Filed Oct 19 1921

Registrar.

Registrar.

2

145701

ST
DEPARTMENT
BUREAU OF
H

CERTIFICATE

DATE OF BIRTH

Handwritten signature

FORM V. S. No. 25 M. 1-19.

RECEIVED OCT 13 1926		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH Washington		Registration District No. 56		File No. 55019	
County of Weiser		Primary Registration District No. 1010		Registered No. 14	
City of Weiser		(No. 1010) St. Weiser		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME Baby English		MEDICAL CERTIFICATE OF DEATH 1890	
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX 7	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)			
6. DATE OF BIRTH Sept 13 1926 (Month) (Day) (Year)					
7. AGE Steel born		IF LESS than 1 day how many hrs. or min.?			
8. OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business or establishment in which employed (or employer)					
9. BIRTHPLACE (State or Country) Weiser Idaho					
10. NAME OF FATHER Arthur F English					
11. BIRTHPLACE OF FATHER (State or Country) Pueblo Colorado					
12. MAIDEN NAME OF MOTHER Clara De Biaso					
13. BIRTHPLACE OF MOTHER (State or Country) Chandler Colorado					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Sign Arthur English (Address) Weiser Oregon					
15. Filed Sept. 14 th 1926 N. R. Hamilton Local Registrar					
16. DATE OF DEATH Sept 13 th 1926 (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1926 to 1926 that I last saw her alive on 1926 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows: still born (Duration) Yrs. mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) G. M. Harker M. D. (Address) Weiser Idaho					
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. days In the State yrs. mos. days Where was disease contracted if not at place of death? Former or usual residence					
19. PLACE OF BURIAL OR REMOVAL Weiser Cemetery				DATE OF BURIAL 9-14 1926	
20. UNDERTAKER L. C. Plonk				ADDRESS Weiser Ida	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

619-106-006-419
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
NOV 3
CERTIFICATE OF BIRTH

STOP

County of Ada

City of Town

No. _____ St. Registration District No. 2 State File No. 145758

Hospital St. Alphonsus Primary Registration District No. 1004 Local Registrar's No. 427

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Oct 6</u> 192 <u>6</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER	
FULL NAME <u>Harry A. Woods</u>	
RESIDENCE <u>Unknown</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Wash.</u>	
OCCUPATION <u>Mechanic</u>	

MOTHER	
FULL MAIDEN NAME <u>Virginia Martin</u>	
RESIDENCE <u>1513 Main Town</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Charleston W. Va.</u>	
OCCUPATION <u>Factory worker</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 10 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F. E. Barrett M. D.
Town Ada
(Physician or midwife)

Address _____
Filed 10-8 192 6 R. H. Pratt
Registrar.

For the above and other reasons, the Court is of the opinion that the writ should be granted.

CONFIDENTIAL

LEFT NAME OF CHILD

10-22-68
HHC

There has been one notable exception and W

Number of child of this mother included in study

NAME
FURN

SCIENCE

color

AGE 21 LAST
BIRTHDAY

37A 1941918

OCCUPATION

DATE: 11/11/1988

MOITARUSSO

5010

WESLINGTON

NAME
MADAM

SYSTEM

(100) 100%

DECLASSIFIED

857641

No. _____ St. Registration District No. _____ File No. _____

[illegible]

Class _____ Date _____

Number of
order of
said to

11/29/11
11/16/11

02:11
14:14

(vco)

SHI
(L20V)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

Give names added from a supplemental report.

(offered to subject)

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

473-126 RECEIVED OCT 20 1926
00-473 PLACE OF BIRTH

Form V. S. No. 11-C--25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S145831

County of Ada

City of Burley

Registration District No. 2

File No. _____

No. _____ St. _____

Hospital St. Luke's

Primary Registration District No. 1004

Registered No. 415

FULL NAME OF CHILD

Edward Epton

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of Birth <u>June 26,</u> (Month) (Day) (Year)
--------------------------	---	-----	---	---------------------------	---

FATHER
FULL NAME A. R. Epton
RESIDENCE Burley, Idaho
COLOR White
AGE AT LAST BIRTHDAY 36
(Years)
BIRTHPLACE Louisiana
OCCUPATION Automobile Salesman

MOTHER
FULL MAIDEN NAME Mrs. A. R. Epton
RESIDENCE Burley, Idaho
COLOR White
AGE AT LAST BIRTHDAY 36
(Years)
BIRTHPLACE Mass.
OCCUPATION Housewife

Number of child of this mother, including present birth _____ Number of children of this mother now living, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn, at 7:00 P. M. on the date above stated.
(Born alive or stillborn)

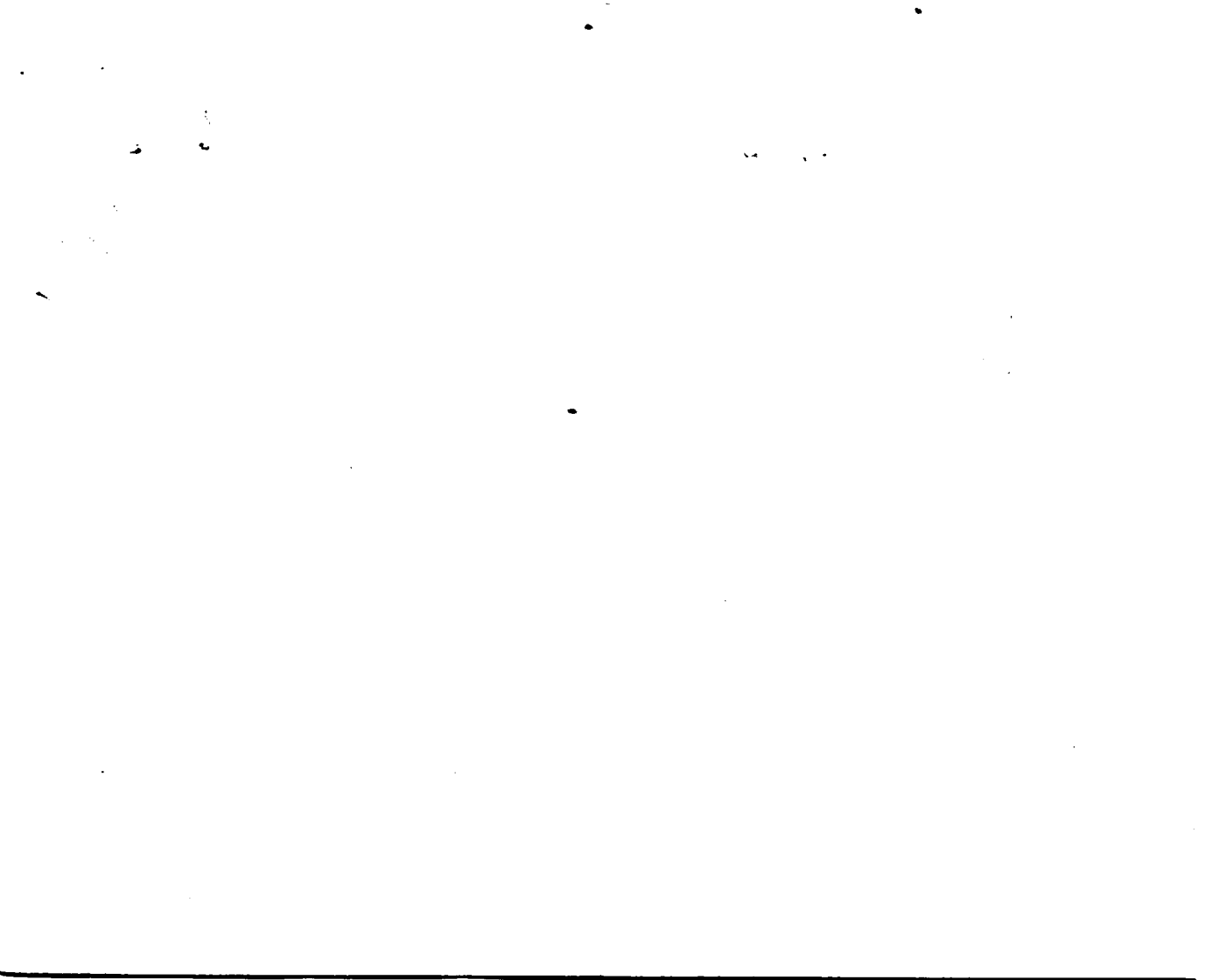
*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. M. Davis
J. M. Davis
(Physician or midwife)

Given names added from a supplemental report.

Address 304-04 Overland Blvd
Filed 10-15 19 26 P. H. Pratt
Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

JUL 1

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH **BUREAU OF VITAL STATISTICS** CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **53707**

County of **Ada** Registration District No. **3**

City of **Bose** Primary Registration District No. **1994**

Local Registrar's No. **169**

(No. **St. Lukes Hospital**)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **John. Lipton**

(a) Residence No. **Wylie Station** St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **M** 4 COLOR OR RACE **White** 5 Single, Married, Widowed, or Divorced (write the word) **Single**

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) **Bose Idaho**

10 NAME OF FATHER **Geo R. Lipton**

11 BIRTHPLACE OF FATHER (city or town) (State or country) **Massachusetts**

12 MAIDEN NAME OF MOTHER **Frances Small**

13 BIRTHPLACE OF MOTHER (city or town) (State or country) **Idaho City**

14 Informant **Geo R. Lipton** (Address) **1000 Bryant Motor Co. Boise**

15 Date **June 28, 1926** Registrar **A. H. Hadd**

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 26 19 **26**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **June 26, 1926** to **June 26, 1926**, that last saw him **live** on **June 26, 1926** and that death occurred, on the date stated above, at **7:00** m.

The CAUSE OF DEATH was as follows:

Stiff neck

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) **Dr. J. W. Dams** M. D.

June 28, 1926 (Address) **Boise, Idaho**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Marion's This Cemetery **June 28, 1926**

20 Undertaker Address

Summers & Thibe Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

613-106-
006-000
DEPARTMENT OF COMMERCE—BUREAU OF THE CENSUS
February 1926
State File No. _____
Registered No. A1

RECEIVED SEP 8 1928 STANDARD CERTIFICATE OF BIRTH

1. PLACE OF BIRTH
County It Hall Reservation State Idaho
Township _____ or Village _____
City _____ No. _____ St. _____ Ward _____
(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child Alex Waterhouse (If child is not yet named, make supplemental report, as directed)

3. Sex of child <u>Male</u>	To be answered ONLY in event of plural births.	4. Twin, triplet or other _____	5. Legit. male? <u>yes</u>	6. Date of birth <u>Feb. 6 1926</u> (Month, day, year)
8. Full name <u>Johnny Waterhouse</u>		14. Full maiden name <u>Azahovrah</u>		
9. Residence <u>It Hall Reservation</u> (Usual place of abode) If nonresident, give place and State		15. Residence <u>It Hall Reservation</u> (Usual place of abode) If nonresident, give place and State		
10. Color or race <u>Ind. 4/4</u>	11. Age at last birthday <u>4 2/3</u> (Years)	16. Color or race <u>Ind 4/4</u>	17. Age at last birthday <u>18</u> (Years)	
12. Birthplace (city or place) (State or country) <u>It Hall Reservation</u>		18. Birthplace (city or place) (State or country) <u>It Hall Reservation</u>		
13. Occupation Nature of Industry <u>Farming</u>		19. Occupation Nature of Industry <u>Housewife</u>		
20. Number of children of this mother (Taken as of time of birth of child herein certified and including this child.)		(a) Born alive and now living <u>3</u> (b) Born alive but now dead <u>3</u> (c) Stillborn <u>0</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5 a. m. on the date above stated.
(Born alive or stillborn.)

Signature Henry R. Wheeler

(Physician or Midwife)

Given name added from
a supplemental report _____
(Month, day, year)

Address It Hall, Idaho
Filed _____, 19____

WHY BIRTHS SHOULD BE REGISTERED

There is hardly a relation of life, social, legal, or economic, in which the evidence furnished by an accurate registration of births may not prove to be of the greatest value, not only to the individual but also to the public at large. It is not only an act of civilization to register birth certificates but good business, for they are frequently used in many practical ways:

- (1) As evidence to prove the age and legitimacy of heirs;
- (2) As proof of age to determine the validity of a contract entered into by an alleged minor;
- (3) As evidence to establish age and proof of citizenship and descent in order to vote;
- (4) As evidence to establish the right of admission to the professions and to many public offices;
- (5) As evidence of legal age to marry;
- (6) As evidence to prove the claims of widows and orphans under the widows' and orphans' pension law;
- (7) As evidence to determine the liability of parents for the debts of a minor;
- (8) As evidence in the administration of estates, the settlement of insurance and pensions;
- (9) As evidence to prove the irresponsibility of children under legal age for crime and misdemeanor, and various other matters in the criminal code;
- (10) As evidence in the enforcement of law relating to education and to child labor;
- (11) As evidence to determine the relations of guardians and wards;
- (12) As proof of citizenship in order to obtain a passport;
- (13) As evidence in the claim for exemption from or the right to jury and military service.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH		1926	
DEPARTMENT OF COMMERCE		BUREAU OF VITAL STATISTICS	
1 PLACE OF DEATH County <u>St. Hall Reservation</u> State <u>Idaho</u>		Registered No. <u>55301</u>	
2 City <u>Idaho</u> or Village _____ or _____		No. _____ St. _____ Ward _____	
(If death occurred in a hospital or institution, give its NAME instead of street and number)			
3 NAME OF DECEASED <u>Alex. Waterhouse</u>			
(a) Residence. No. _____ St. _____ Ward _____ (Usual place of abode) Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident give city or town and State)			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Ind 4/4</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>	
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____			
6 DATE OF BIRTH (month, day, and year) <u>Feb 6, 1926</u>			
7 AGE	Years <u>0</u>	Months <u>0</u>	Days <u>0</u>
If LESS than 1 day, --- hrs. or --- min.			
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____			
9 BIRTHPLACE (city or town) (State or country) <u>St. Hall Reservation</u>			
10 NAME OF FATHER <u>Johnny Waterhouse</u>			
11 BIRTHPLACE OF FATHER (city or town) (State or country) <u>St. Hall Reservation</u>			
12 MAIDEN NAME OF MOTHER <u>Azahoveah</u>			
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <u>St. Hall Reservation</u>			
14 Informant <u>Mrs. Johnny Waterhouse</u> (Address) <u>St. Hall, Idaho</u>			
15 Filed _____, 19 _____ REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH (month, day, and year) <u>Feb. 6, 1926</u>			
17 By doctor attending I HEREBY CERTIFY, That I attended deceased from _____, 19 _____, to _____, 19 _____, that I last saw him _____ alive on _____, 19 _____, and that death occurred, on the date stated above, at <u>5 a</u> .m. The CAUSE OF DEATH* was as follows: <u>Stillborn at term</u>			
CONTRIBUTORY (duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. (SECONDARY) <u>Due to weather</u> (duration) _____ yrs. _____ mos. <u>5</u> ds.			
18 Where was disease contracted If not at place of death? <u>No</u>			
Did an operation precede death? <u>No</u> Date of _____			
Was there an autopsy? <u>No</u>			
What test confirmed diagnosis? <u>None</u> (Signed) <u>Henry R. Wheeler</u> , M. D. , 19 _____ (Address) <u>St. Hall, Idaho</u>			
* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)			
19 PLACE OF BURIAL, CREMATION, OR REMOVAL <u>St. Hall Reservation</u>		DATE OF BURIAL <u>Feb. 7, 1926</u>	
20 UNDERTAKER <u>Johnny Waterhouse</u>		ADDRESS <u>St. Hall, Idaho</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Coal engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report properly the occupations of persons engaged in domestic life for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the person has been changed or given up on account of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Pneumothorax*; *Pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsion," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undecipherable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

756-207.
1006-756

DEPARTMENT OF COMMERCE—BUREAU OF THE CENSUS

March 1926

State File No.

RECEIVED SEP 8 1926 STANDARD CERTIFICATE OF BIRTH

Registered No.

7A

145877

1. PLACE OF BIRTH—

County

Bannock

State

Idaho

Township

City

Pocatello Idaho

or Village

No. Lynn Bros Hospital St.

Ward

(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child

Sophia George

(If child is not yet named, make supplemental report, as directed)

3. Sex of child

Female

To be answered ONLY in event of plural births.

4. Twin, triplet or other

5. Number, in order of birth

6. Legible marks?

No

7. Date of birth

Mch 7 1926

(Month, day, year)

8. Full name

FATHER

Unknown

9. Residence

(Usual place of abode)

If nonresident, give place and State

Unknown

10. Color or race

11. Age at last birthday

(Years)

12. Birthplace (city or place)

(State or country)

Unknown

13. Occupation

Nature of Industry

Unknown

14. Full maiden name

MOTHER

Josephine George

15. Residence

(Usual place of abode)

If nonresident, give place and State

St. Hall Reservation

16. Color or race

Ind 4/4

17. Age at last birthday

25

(Years)

18. Birthplace (city or place)

(State or country)

St. Hall Reservation

19. Occupation

Nature of Industry

Keeping house

20. Number of children of this mother
(Taken as of time of birth of child herein certified and including this child.)

(a) Born alive and now living

2

(b) Born alive but now dead

0

(c) Stillborn

1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7 a m. on the date above stated.
Witnessed by Dr. Lynn Pocatello, Idaho (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Signature

Henry R. Wheeler

Physician
(Physician or Midwife)

Given name added from a supplemental report

(Month, day, year)

Address

St. Hall, Idaho

Filed

19

WHY BIRTHS SHOULD BE REGISTERED

There is hardly a relation of life, social, legal, or economic, in which the evidence furnished by an accurate registration of births may not prove to be of the greatest value, not only to the individual but also to the public at large. It is not only an act of civilization to register birth certificates but good business, for they are frequently used in many practical ways:

- (1) As evidence to prove the age and legitimacy of heirs;
- (2) As proof of age to determine the validity of a contract entered into by an alleged minor;
- (3) As evidence to establish age and proof of citizenship and descent in order to vote;
- (4) As evidence to establish the right of admission to the professions and to many public offices;
- (5) As evidence of legal age to marry;
- (6) As evidence to prove the claims of widows and orphans under the widows' and orphans' pension law;
- (7) As evidence to determine the liability of parents for the debts of a minor;
- (8) As evidence in the administration of estates, the settlement of insurance and pensions;
- (9) As evidence to prove the irresponsibility of children under legal age for crime and misdemeanor, and various other matters in the criminal code;
- (10) As evidence in the enforcement of law relating to education and to child labor;
- (11) As evidence to determine the relations of guardians and wards;
- (12) As proof of citizenship in order to obtain a passport;
- (13) As evidence in the claim for exemption from or the right to jury and military service.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

55464

1 PLACE OF DEATH

County

Bannock

State

Idaho

Registered No. *A1*

Township

Pocatello, Idaho

or Village

No. Lunn. Hos. Hospital

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Lopha George

(a) Residence. No.

(Usual place of abode)

St., Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Ind 4/4

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mch 7 - 1926

7 AGE

Years

Months

Days

If LESS than 1 day, --- hrs. or --- min.

0

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pocatello, Idaho

PARENTS

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

Josephine George

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

St. Hall Reservation

14

Informant (Address)

*Shanty George
St. Hall, Idaho*

15

Filed

, 19

REGISTRAR

11-3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Mch 7 - 1926

Deceased by Dr. Lunn. Pocatello, Idaho

I HEREBY CERTIFY, That I attended deceased from

, 19

to

, 19

that I last saw h..... alive on

, 19

and that death occurred, on the date stated above, at *7 a* m.

The CAUSE OF DEATH* was as follows:

Stillborn at term

(duration)

0 yrs.

0 mos.

0 ds.

CONTRIBUTORY

(SECONDARY)

(duration)

0 yrs.

0 mos.

0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No*

Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *None*

(Signed)

Henry R. Wheeler

M. D.

, 19 (Address)

St. Hall, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Hall Reservation

Mch 9 - 1926

20 UNDERTAKER

ADDRESS

Agency Carpenter

St. Hall, Idaho

MARGIN RESERVED FOR BINDING

1-200 4

V. B. No. 98

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DO NOT WRITE IN THE MARGINS. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exert every effort to OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
BUREAU OF VITAL STATISTICS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The married worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anemia," (merely symptoms

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, eclampsia, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

11—3164

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

814-209- 006-814		DEPARTMENT OF COMMERCE—BUREAU OF THE CENSUS		May 1926	
RECEIVED SEP 8 1926		STANDARD CERTIFICATE OF BIRTH		State File No. _____	
1. PLACE OF BIRTH		County <u>Et. Hall Reservation</u> State <u>Idaho</u>		Registered No. <u>145885</u>	
Township _____		or Village _____		Ward _____	
City _____		No. _____		St. _____	
		(If birth occurred in a hospital or institution, give its NAME instead of street and number)			
2. Full name of child <u>May Hammer</u>				(If child is not yet named, make supplemental report, as directed)	
3. Sex of child <u>Female</u>	To be answered ONLY in event of plural births.	4. Twin, triplet or other _____	5. Legit. mat. <u>No</u>	6. Date of birth <u>May 9 1926</u>	(Month, day, year)
8. FATHER Full name <u>Unknown</u>		14. MOTHER Full maiden name <u>Clara Hammer</u>			
9. Residence (Usual place of abode) If nonresident, give place and State <u>Unknown</u>		15. Residence (Usual place of abode) If nonresident, give place and State <u>Et. Hall Reservation</u>			
10. Color or race <u>Unknown</u>	11. Age at last birthday <u>Unknown</u> (Years)	16. Color or race <u>Ind 4/4</u>	17. Age at last birthday <u>25</u> (Years)		
12. Birthplace (city or place) (State or country) <u>Unknown</u>		18. Birthplace (city or place) (State or country) <u>Lernhi Reservation</u>			
13. Occupation Nature of Industry <u>Unknown</u>		19. Occupation Nature of Industry <u>Housewife</u>			
20. Number of children of this mother (Taken as of time of birth of child herein certified and including this child.)		(a) Born alive and now living <u>0</u>		(b) Born alive but now dead <u>0</u>	
		(c) Stillborn <u>1</u>			
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*					
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>9 P.</u> m. on the date above stated.					
(Born alive or stillborn.)					
Signature <u>Henry R. Wheeler</u> Physician (Physician or Midwife)					
Given name added from a supplemental report _____		Address <u>Et. Hall, Idaho</u>			
(Month, day, year)		Filed _____, 19____		Registrar.	

WHY BIRTHS SHOULD BE REGISTERED

There is hardly a relation of life, social, legal, or economic, in which the evidence furnished by an accurate registration of births may not prove to be of the greatest value, not only to the individual but also to the public at large. It is not only an act of civilization to register birth certificates but good business, for they are frequently used in many practical ways:

- (1) As evidence to prove the age and legitimacy of heirs;
- (2) As proof of age to determine the validity of a contract entered into by an alleged minor;
- (3) As evidence to establish age and proof of citizenship and descent in order to vote;
- (4) As evidence to establish the right of admission to the professions and to many public offices;
- (5) As evidence of legal age to marry;
- (6) As evidence to prove the claims of widows and orphans under the widows' and orphans' pension law;
- (7) As evidence to determine the liability of parents for the debts of a minor;
- (8) As evidence in the administration of estates, the settlement of insurance and pensions;
- (9) As evidence to prove the irresponsibility of children under legal age for crime and misdemeanor, and various other matters in the criminal code;
- (10) As evidence in the enforcement of law relating to education and to child labor;
- (11) As evidence to determine the relations of guardians and wards;
- (12) As proof of citizenship in order to obtain a passport;
- (13) As evidence in the claim for exemption from or the right to jury and military service.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County

Idaho
St. Hall Reservation State—*Idaho*

55472

Registered No. *A 2*

RECEIVED

OCT 18

BUREAU OF VITAL STATISTICS

May Hammer

(a) Residence. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Ind 4/4

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 9 - 1926

7 AGE

Years

Months

Days

If LESS than

0

0

0

1 day, --- hrs.
or --- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

St. Hall Reservation

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Clara Hammer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Lewish Reservation

14

Informant

Clara Hammer

(Address)

St. Hall, Idaho

15

Filed

19

REGISTRAR

11-3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 9 1926

17 *No doctor attending*
I HEREBY CERTIFY, that I attended deceased from

19-----, to 19-----,

that I last saw h----- alive on 19-----,

and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH* was as follows:

Stillborn at term

CONTRIBUTORY

(SECONDARY)

(duration) 0 yrs. 0 mos. 0 ds.

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes* - *May 13 - 1926*

What test confirmed diagnosis? *None*

(Signed) *Henry R. Wheeler* M. D.

19 (Address) *St. Hall, Idaho*

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Hall Reservation *May 13, 1926*

20 UNDERTAKER

ADDRESS

Agency Carpenter *St. Hall Idaho*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Tramia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undetectable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

11—3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

PLACE OF RECEIVED NOV 15 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 145968

County of Lawrence, Bannock
 City of Lawrence
 No. 299-227-003884 St. Registration District No. 2-3 State File No. -
 Hospital - Primary Registration District No. 2160 Local Registrar's No. 25-8

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>-</u>	and { Number in order of birth <u>-</u> }	Legitimate? <u>Yes</u>	Date of birth <u>Oct 27</u> 192 <u>6</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>14</u>		Number of child of this mother now living, including present birth <u>0</u>	
FULL NAME FATHER <u>Willie Brinn</u>	FULL MAIDEN NAME MOTHER <u>Emma Kyle</u>	FULL NAME FATHER <u>Willie Brinn</u>	FULL MAIDEN NAME MOTHER <u>Emma Kyle</u>
RESIDENCE <u>Lawrence Idaho</u>	RESIDENCE <u>Lawrence Idaho</u>	RESIDENCE <u>Lawrence Idaho</u>	RESIDENCE <u>Lawrence Idaho</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Lawrence, Ida.</u>	BIRTHPLACE <u>Lawrence, Idaho</u>	BIRTHPLACE <u>Lawrence, Ida.</u>	BIRTHPLACE <u>Lawrence, Idaho</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 3-20 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

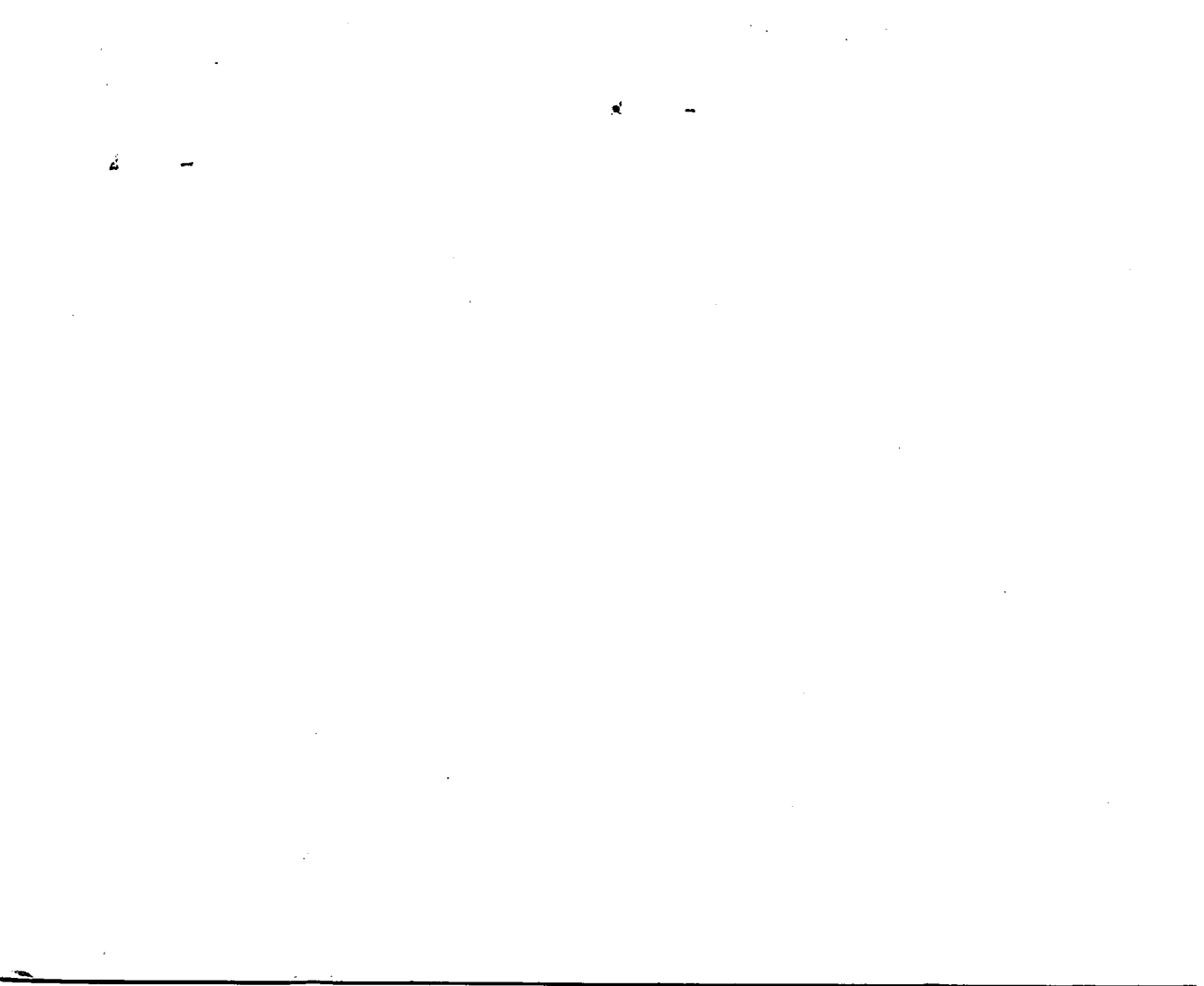
Address

Filed

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



RECEIVED NOV 15 1926

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of DawsonRegistration District No. 88Primary Registration District No. 2160

(No. _____ St.)

File No. 55099Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Brim

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

Oct-27-1926
(Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Dawson, Idaho

10. NAME OF FATHER

Willis Brim

11. BIRTHPLACE OF FATHER

(State or Country)

Dawson, Ida

12. MAIDEN NAME OF MOTHER

Ema Byde

13. BIRTHPLACE OF MOTHER

(State or Country)

Dawson, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Willis Brim
Dawson, Ida

15.

Filed Nov-10-1926Mary C. Coffin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct-27-26
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct-27-1926, to Oct-27-1926

that I last saw him _____ alive on _____ 19____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

difficult prolonged laborStillborn
(Duration) _____ Yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. J. Hartigan, M. D.
Oct 29 1926 (Address) Dawson, Idaho

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the _____ State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name or. gin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED OCT 21 1926 STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of BenevolahCity of New Benevolah P.O.

CERTIFICATE OF BIRTH

No. 329 211005 997 St. Registration District No. 32 State File No. 145986Hospital _____ Primary Registration District No. 2049 Local Registrar's No. 72FULL NAME OF CHILD Carrie Bell Clinton

(Certificate of no value without full name of child)

Sex of Child <u>female</u>	Twin Triplet or other? <input checked="" type="checkbox"/>	and { Number in order of birth <u>✓</u>	Legitimate? <u>yes</u>	Date of birth <u>Sept 11</u> 192 <u>6</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? Boric acidNumber of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME George N. Clinton
RESIDENCE Benevolah P.R.
COLOR white AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE Mich
OCCUPATION Ranching

MOTHER
FULL MAIDEN NAME Alta B. Riggs
RESIDENCE Benevolah P.R.
COLOR white AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Wash.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 9:00 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) George N. Clinton

(Physician or midwife)

Address Benevolah P.R. IdahoFiled Oct 8 1926 Ozmerag

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

AUG 23 1943

Don

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

673-116-008-287
PLACE OF BIRTH RECEIVED NOV 5 1926 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Bingham
City of Blackfoot
No. R.D.# 1 St. Registration District No. 121 State File No. 146032
Hospital _____ Primary Registration District No. 2194 Local Registrar's No. 360
FULL NAME OF CHILD (Stillborn) Walker
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? Yes Date of birth Oct 16 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth <u>4</u>		Number of child of this mother now living, including present birth <u>1</u>	
FULL NAME	FATHER <u>George L. Walker</u>	FULL MAIDEN NAME	MOTHER <u>Roseella Sharp</u>
RESIDENCE	<u>Blackfoot</u>	RESIDENCE	<u>Blackfoot</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>33</u> (Years)	AGE AT LAST BIRTHDAY	<u>30</u> (Years)
BIRTHPLACE	<u>Utah</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE Stillborn

I hereby certify that I attended the birth of this child, who was { Stillborn } at 5:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

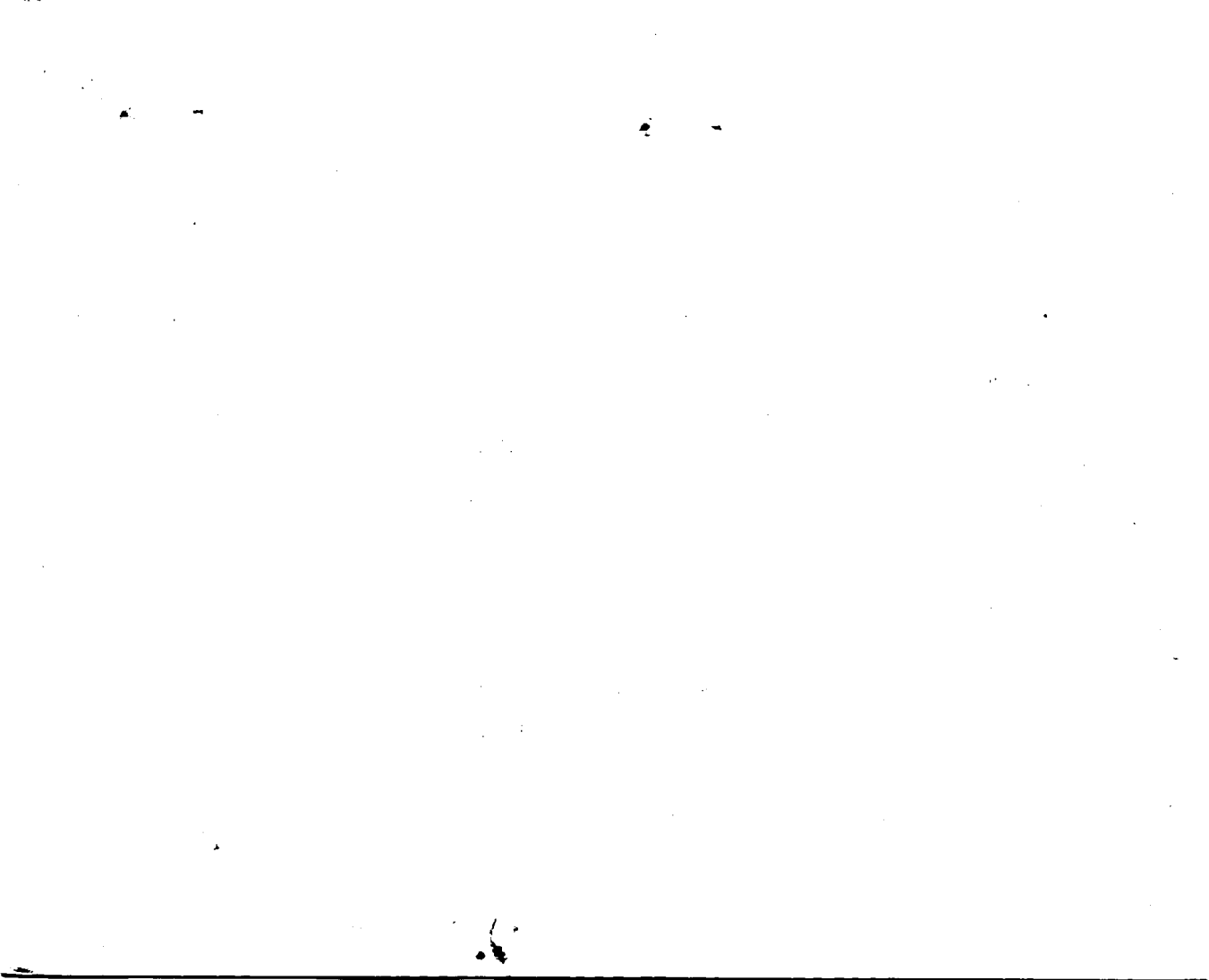
(Signature) W W Beck

(Physician or midwife)
Address Blackfoot, Idaho

Filed Nov 1 1926 Mrs. Valer Etobine

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. NO. 5-25 M. 1-19.

NOV 5 1976

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bingham
City of BlackfootRegistration District No. 121Primary Registration District No. 2194

(No. _____ St.)

State File No. 55117Local Registrar's No. 121

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No Name Walker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

October 16 1976
(Month) (Day) (Year)

7. AGE

StillbornIF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

George C. Walker

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Rosella Sharp

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. C. Walker(Address) Blackfoot, Idaho

15.

Filed Oct. 18 1976Mo. Walker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

last date mother felt
About Oct 16 1976
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1976 to Stillbirth 1976,
that I last saw him alive on Stillbirth 1976,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Had been dead
for several weeks
Stillborn at 6 1/2 mo
(Duration) _____ yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. W. Buck M. D.
10/18/1976 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

G. C. Walker Ranch

DATE OF BURIAL

Oct. 18, 1976

20. UNDERTAKER

G. C. Muller

ADDRESS

121 - Route 1

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

PLACE OF BIRTH **RECEIVED NOV 5 - 1926**STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of BinghamCity of Shelley

CERTIFICATE OF BIRTH

No. 415 128 006 846 St.Registration District No. 121State File No. 146043

Hospital

Primary Registration District No. 2194Local Registrar's No. 371

FULL NAME OF CHILD

Baby Davis

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?
(To be answered only in event of plural births)

}

and {

Number
in order
of birthLegiti-
mate?yesDate of
birth10-25- 1926
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

5FULL
NAME

FATHER

Cyrus C. Davis

RESIDENCE

Shelley

COLOR

White

AGE AT LAST

BIRTHDAY

38
(Years)

BIRTHPLACE

Mo.

OCCUPATION

Lumber SalesmanFULL
MAIDEN
NAME

MOTHER

Maud Hufferaker

RESIDENCE

Shelley

COLOR

White

AGE AT LAST

BIRTHDAY

38
(Years)

BIRTHPLACE

Idaho

OCCUPATION

House Keeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive 5 30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

Eburi Carter MD

(Physician or midwife)

Address

Shelley Idaho

Filed

Nov. 3 1926 M. L. Loring

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

I hereby certify that I attended the fifth of
on the date above stated.

I hereby certify that I attended the birth of this child, who was

COPIATION

514791

COLOR

40103

BY THE

1107
2015

Number of child in the mother now living, including present - (1940)

1. The first step is to identify the problem. This involves understanding the current situation and what needs to be improved.

11/11/11
10/11/11

10-2-12
51161

GOING TO SEA 1942

11/11/11
10/11/11

Registration District No. 14 State File No.

CHARTER OF RIGHTS

2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH 258-228009 992 RECEIVED NOV 6 - 1926 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
County of Banner
City of Sandpoint
No. _____ St. _____ Registration District No. 76 State File No. 146059
Hospital _____ Primary Registration District No. 2155 Local Registrar's No. _____
FULL NAME OF CHILD Stillbirth
(Certificate of no value without full name of child)

Sex of Child Female { Twin or other? } and { Number in order of birth } Legitimate? yes Date of birth 10 - 28 - 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4th Number of child of this mother now living, including present birth 3

FATHER		MOTHER	
FULL NAME	<u>Howard Wendell Hayes</u>	FULL MAIDEN NAME	<u>Jennie Rising</u>
RESIDENCE	<u>Sandpoint</u>	RESIDENCE	<u>Sandpoint</u>
COLOR	<u>W white</u>	COLOR	<u>W white</u>
AGE AT LAST BIRTHDAY	<u>33</u> (Years)	AGE AT LAST BIRTHDAY	<u>36</u> (Years)
BIRTHPLACE	<u>Michigan</u>	BIRTHPLACE	<u>Washington</u>
OCCUPATION	<u>Deliveryman</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 2:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address Sandpoint, Idaho

Filed Nov 3 1926

Registrar.

Viola Allen
Deputy Registrar.

4

2

4

1

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 6 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

55138

State File No.....

Local Registrar's No.....

PLACE OF DEATH

County of Donner
City of Sandpoint

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2135

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Reyes

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Oct. 28, 1926

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. _____ min. Stillborn

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

10 NAME OF FATHER Howard Reyes

11 BIRTHPLACE OF FATHER (city or town) Bromson
(State or country) Michigan

12 MAIDEN NAME OF MOTHER Jennie Rising

13 BIRTHPLACE OF MOTHER (city or town) Seattle
(State or country) Wash

14 Informant Howard Reyes
(Address) Sandpoint Ida.

15 Filed Oct 29, 1926 Viola Allen
Registrar

MEDICAL CERTIFICATE OF DEATH 1896

16 DATE OF DEATH

Oct 28 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1926 to Oct 28, 1926

that I last saw h. _____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn, Birth injuries.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) N. B. Walling, M. D.

10/29 1926 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Laborer Cemetery Date of Burial Oct. 29 1926

20, Undertaker L. E. Moon Address Sandpoint Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED NOV 19 1926

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

493-226010-253

County of Bonneville

City of Idaho Falls

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 23 State File No. 146100

Hospital L. O. S. Primary Registration District No. 2 N. 2 Local Registrar's No. 4-12

FULL NAME OF CHILD Miller

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>X</u>	and { Number in order of birth <u>2</u> }	Legitimate? <u>yes</u>	Date of birth <u>9/26</u> 192 <u>6</u>
(To be answered only in event of plural births)			(Month) (Day) (Year)	

What bactericidal solution was used in eyes? X

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Roderick Miller
RESIDENCE Shelley Idaho
COLOR white AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ellen Kelley
RESIDENCE Shelley Idaho
COLOR white AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at Idaho Falls on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]
(Physician or midwife)

Address Idaho Falls, Id.

Filed Oct 9 1926

Registrar.

Registrar.

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WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED NOV 18 1926
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
CERIFICATE OF BIRTH

St. Registration District No. 73 State File No. 146101
Primary Registration District No. 215 Local Registrar's No. 471
FULL NAME OF CHILD Miller

(Certificate of no value without full name of child)

Sex of Child female Twin 1 and { Number in order of birth } Legitimate? yes Date of birth 9/26 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? X

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Roderick Miller
RESIDENCE Shelley, Idaho
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Elena Kelley
RESIDENCE Shelley, Idaho
COLOR White AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 8 ³⁰ P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

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Registrar.

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WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLATE OF RECEIVED NOV 15 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Cassia

City of Burley

No. R. F. D. # 12 - St.

Hospital 609 112016.331

Registration District No. 117 State File No. 146186

Primary Registration District No. 2196 Local Registrar's No. 3488

FULL NAME OF CHILD Roderick Fairchild

(Certificate of no value without full name of child)

Sex of Child <u>Boy</u>	Twin Triplet or other? <u> }</u> and <u> {</u> Number in order of birth	Legiti- mate? <u> }</u>	Date of birth <u>Sept. 12</u> - <u>ch</u> 192 <u>6</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME George W. Fairchild
RESIDENCE Cabley Ida.
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Cabley
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ethel S. Clark
RESIDENCE Burley Ida
COLOR White AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Garden Utah
OCCUPATION Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) M. A. Olsen

(Physician or midwife)

Address Burley

Filed Nov 15 1926

Registrar.

Registrar.

Don

PLACE OF BIRTH

RECEIVED NOV 13 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

146

146222

County of CusterCity of ChallisNo. 355210019617St. Registration District No. 108State File No. 146

Hospital

Primary Registration District No. 2186Local Registrar's No. 146222

FULL NAME OF CHILD

Unnamed

(Certificate of no value without full name of child)

Sex of Child

FemaleTwin
Triplet
or other?

}

and {

Number
in order
of birthLegiti-
mate?YesDate of
birthSept. 141926

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

5

Number of child of this mother now living, including present birth

4FULL
NAME

FATHER

George Bert Lee

RESIDENCE

Idaho

COLOR

White

AGE AT LAST

BIRTHDAY

33
(Years)

BIRTHPLACE

Idaho

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Josephine Wagner

RESIDENCE

Idaho

COLOR

White

AGE AT LAST

BIRTHDAY

26
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

Edna M. Kenney

Registrar.

(Signature)

C. S. Kirtley M.D.

(Physician or midwife)

Address

Challis, Idaho

Filed

Oct 21 1926Edna M. Kenney

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



11/11/11

NOV 13 1926

FORM V. S. No. 5-25 M. 1-19.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Custer
City of Challis
If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH
Registration District No. 108
Primary Registration District No. 2186
(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 55207
Local Registrar's No. 45
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word)
6. DATE OF BIRTH Sept 10 1926
(Month) (Day) (Year)

7. AGE
IF LESS than 1 day how many
Yrs. 5 Mos. _____ ds. _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER George Bert Lee

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Josephine Wagner

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bert Lee
(Address) Challis, Idaho

15. Filed Oct 21 1926 Charles Kenney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 10 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____,
that I last saw him alive on _____ 19____,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Still born at 5 months. Probably due to injury received by mother 11 days previous
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. J. Harty M. D.
19____ (Address) Challis, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Challis, Ida DATE OF BURIAL Sept 10 1926

20. UNDERTAKER Friends ADDRESS Challis

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED NOV 13 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of CusterCity of ClaytonNo. 763-102 of 1922 St.Registration District No. 128

State File No.

146230

Hospital

Primary Registration District No. 2186Local Registrar's No. 101

FULL NAME OF CHILD

Unnamed

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?

}

and {

Number
in order
of birth

Legitimate?

Yes

Date of birth

Nov 2

1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

0

Number of child of this mother now living, including present birth

0

FULL NAME

FATHER

Stanley Greig

RESIDENCE

Idaho

COLOR

White

AGE AT LAST BIRTHDAY

24
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Laborer

FULL MAIDEN NAME

MOTHER

Mable Grace Baker

RESIDENCE

Idaho

COLOR

White

AGE AT LAST BIRTHDAY

29
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive born at after her death M. on the date above stated. Removed from body of mother

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. L. Hartley M.D.

(Physician or midwife)

Give names added from a supplemental report.

, 192

Address

Idaho

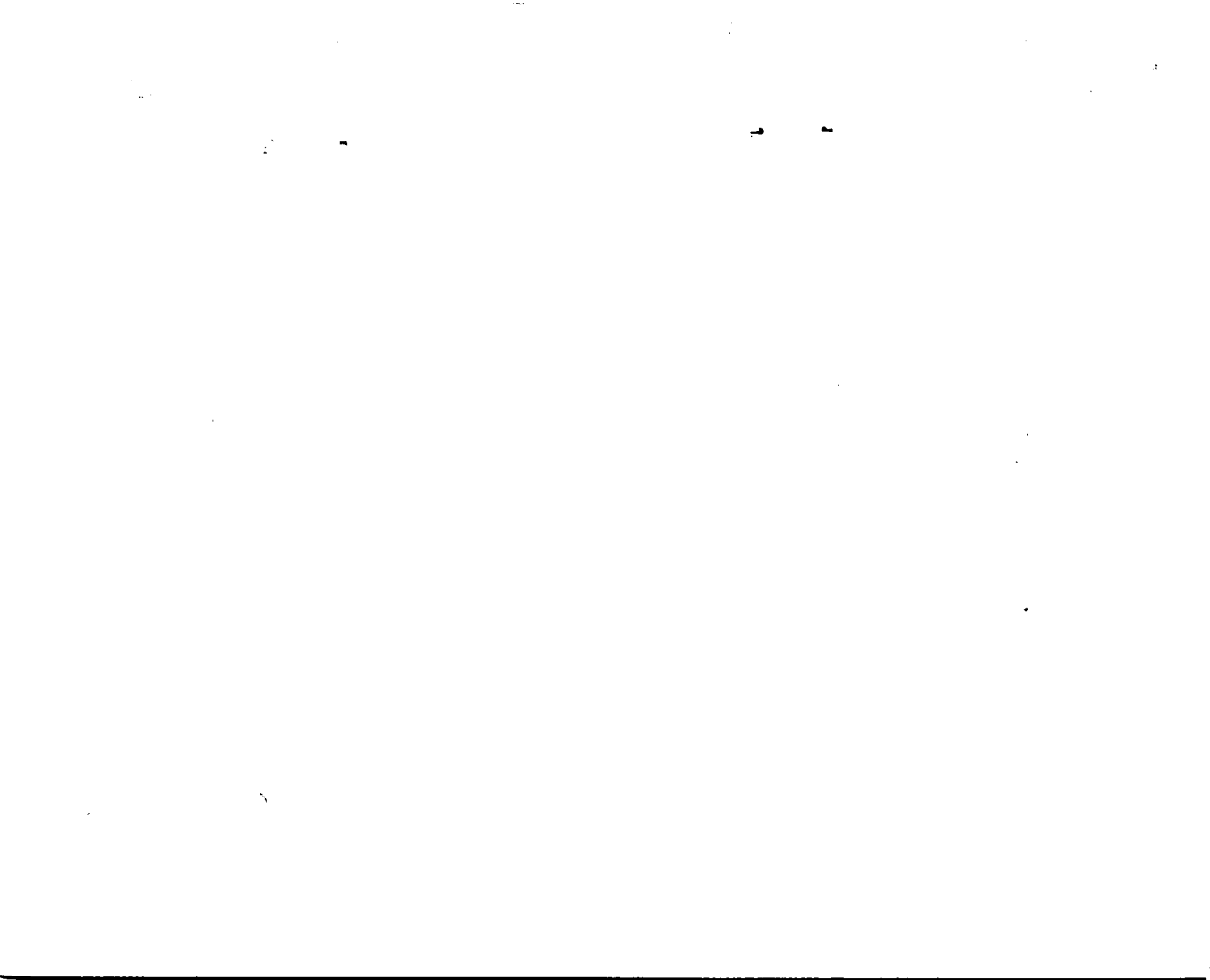
Filed

Nov 6 1926Edna M. Kenney

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V.S. No. 1-25-1-11
RECEIVED NOV 13 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Custer
City of Clayton
If death occurs away from usual residence, give facts called for under special information.
Registration District No. 108
Primary Registration District No. 2186
(No. _____ St.)

State File No. 55210
Local Registrar's No. 48

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word)

6. DATE OF BIRTH
Nov. 2 1926
(Month) (Day) (Year)

7. AGE
IF LESS than 1 day how many
Yrs. Mos. ds. hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF Father Stanley Greig

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mable Grace Baker

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. P. Pennington
(Address) Clayton, Ida.

15. Filed Nov. 6 1926 Edna M. Penney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. 2 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1926 to Nov 2 1926, that I last saw him alive on Nov 2 1926 and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Asphyxiated before birth of child. Child removed at post mortem.
(Duration) 3 yrs. 1 mos. 1 ds.

Contributory (Secondary)
(Duration) 3 yrs. 1 mos. 1 ds.
(Signed) C. L. Bristley M. D.
19 1926 (Address) Clayton, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Clayton
DATE OF BURIAL Nov 2 1926

20. UNDERTAKER none
ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

RECEIVED NOV 5 - 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of BenCity of EmmettNo. 52112023234St. Registration District No. 6State File No. 146270

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD No name

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> (To be answered only in event of plural births)	and { Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>10-12</u> 192 <u>6</u> (Month) (Day) (Year)
--------------------------	---	--	-----------------------------	---

What bactericidal solution was used in eyes? NoneNumber of child of this mother, including present birth 12 Number of child of this mother now living, including present birth 10

FULL NAME FATHER

RESIDENCE William C. AnsbaughCOLOR Emmett IdBIRTHPLACE White AGE AT LAST BIRTHDAY 45 (Years)OCCUPATION PennsylvaniaOCCUPATION Common labor

FULL MAIDEN NAME MOTHER

RESIDENCE Rosie May BlueCOLOR SameBIRTHPLACE White AGE AT LAST BIRTHDAY 45 (Years)OCCUPATION KansasOCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 3-30 a. m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

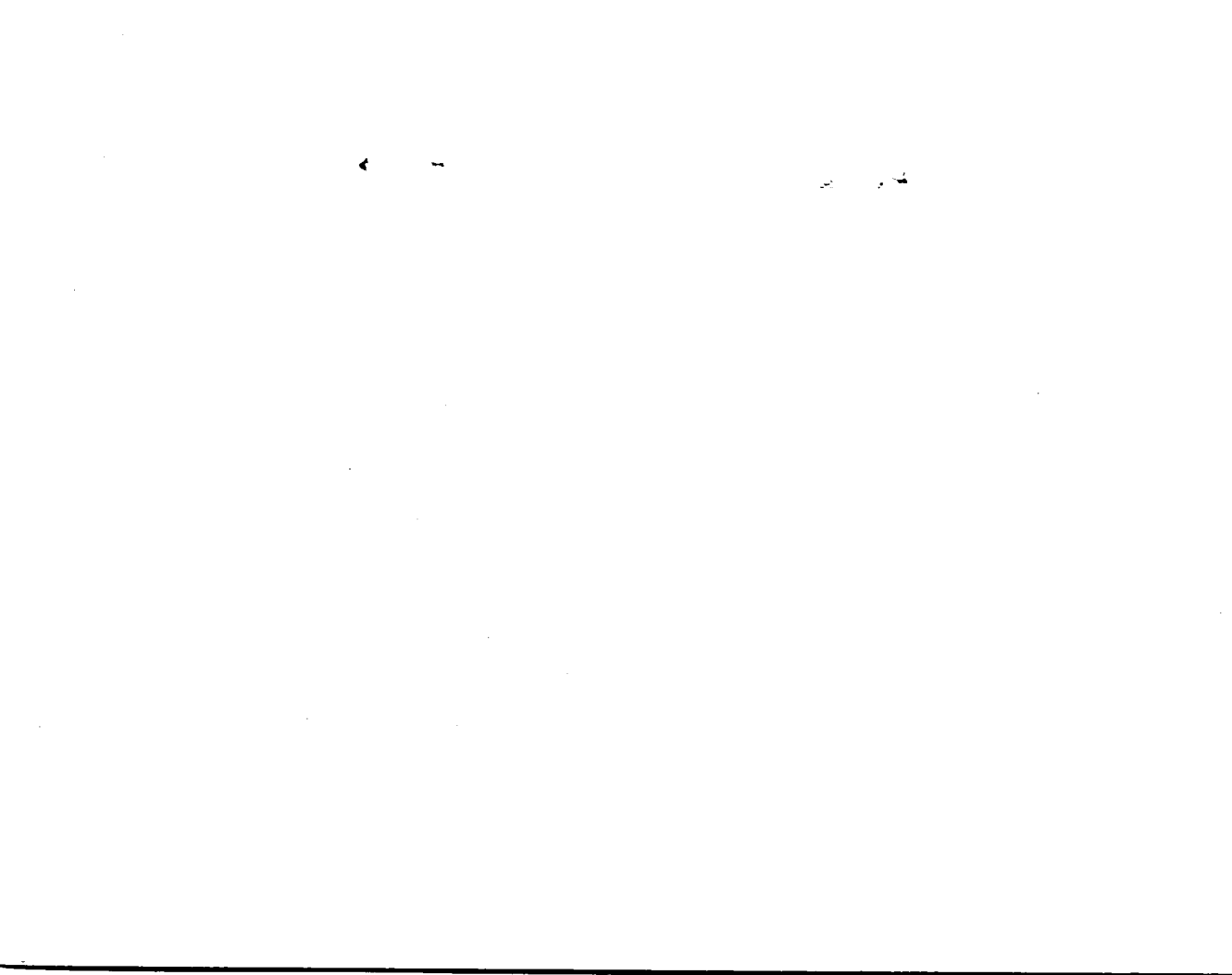
Registrar.

This baby was born while mother (Signature) was alone no physician or doctorin attendance J. Reynolds (Physician or midwife)

Address _____

Filed 10-12 1926 J. Reynolds Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



RECEIVED NOV 5 - 1926

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **55220**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Gem
City of Emmett

Registration District No. _____

Primary Registration District No. 6

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH

10-12-1926
(Month) (Day) (Year)

7. AGE

Still born
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

William C. Anspaugh

11. BIRTHPLACE OF FATHER

(State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER

Bessie May Blue

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm C Anspaugh(Address) Emmett Idaho

15.

Filed 10-12-1926

19

20

Local Registrar J. H. Reynolds

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Baby born dead 10/11/1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

not at all 19____
that I last saw him alive on 19____
and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

This mother has borne a very quiet baby. She said baby made no effort to breathe. It is not known if baby was alive or not.
(Duration) yrs. mos. ds.Contributory I was called later to see mother.
(Secondary) (Duration) yrs. mos. ds.(Signed) J. H. Reynolds M. D.19____ (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett

DATE OF BURIAL

10-12-1926

20. UNDERTAKER

C. A. Buckner

ADDRESS

Emmett

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

493108 024 264

PLACE OF BIRTH RECEIVED NOV 3 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Gooding

City of R. P. I.

No. R. P. I. St.

Registration District No. 24

File No. 146289

Hospital _____ Primary Registration District No. _____ Registered No. 120

FULL NAME OF CHILD Miller

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>10-8</u> 192 <u>6</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth... 3 Number of child of this mother now living, including present birth... 3

FATHER
FULL NAME Rex A. Miller
RESIDENCE Gooding

COLOR White AGE AT LAST BIRTHDAY 25
(Years)

BIRTHPLACE Idaho

OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Josephine Winifred Badenhop
RESIDENCE Gooding

COLOR White AGE AT LAST BIRTHDAY 24
(Years)

BIRTHPLACE Iowa

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born dead at 8:30 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Cornwall M.D.

(Physician or midwife)

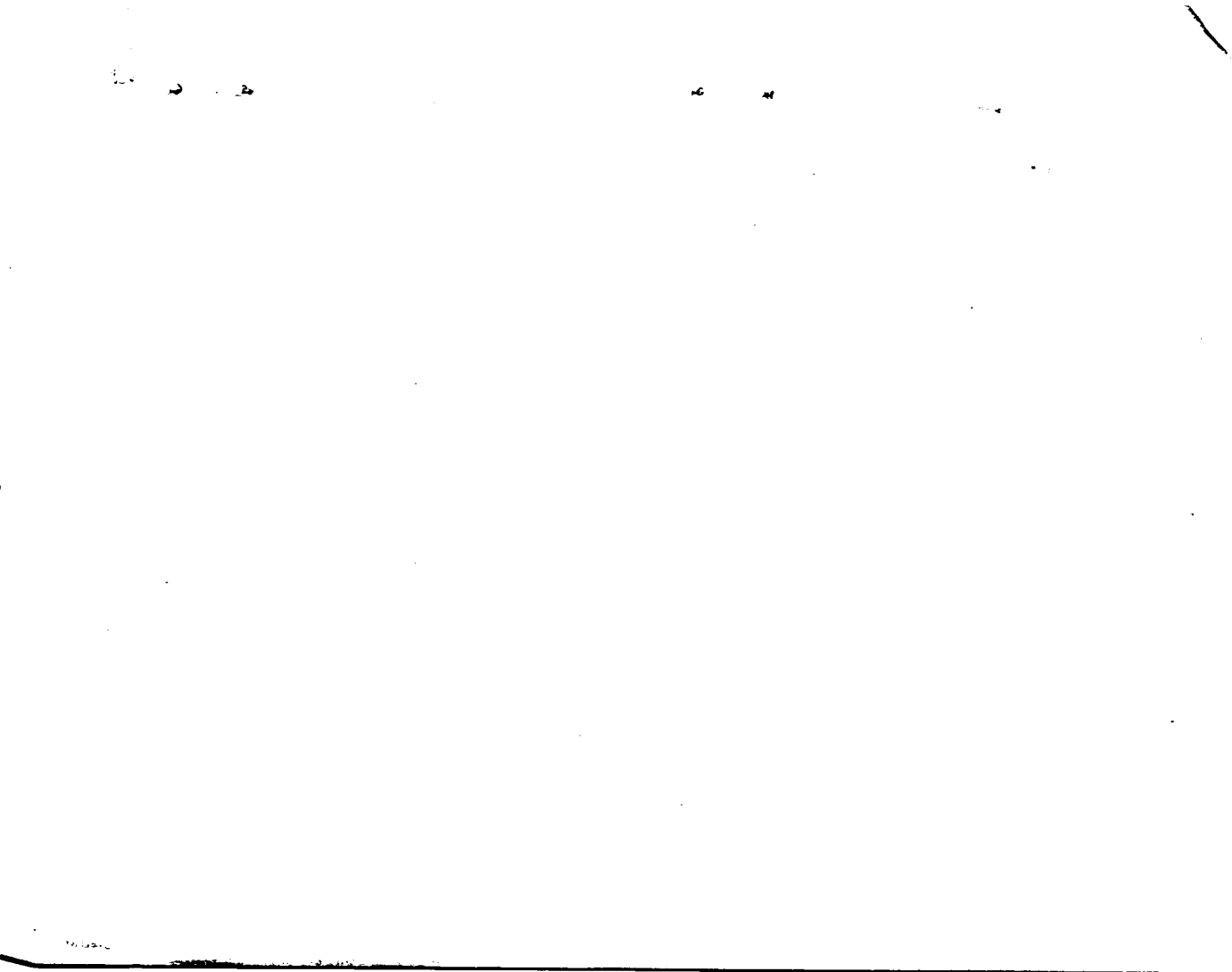
Give names added from a supplemental report.

Address Gooding, Ida

Filed 10-31 1926 J. H. Cornwall

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 3 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 55227

PLACE OF DEATH

County of Gooding
City of Gooding

CERTIFICATE OF DEATH

Registration District No. 24
Primary Registration District No. _____
(No. _____)

Local Registrar's No. 37

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>✓</u>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of <u>✓</u>		
6 DATE OF BIRTH (month, day and year) <u>10-8-26</u>		
7 AGE <u>0</u> Years	<u>0</u> Months	<u>0</u> Days
If LESS than 1 day, <u>0</u> hrs. or <u>0</u> min.		
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>0</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

9 BIRTHPLACE (city or town) Gooding Ida
(State or country) RFO

10 NAME OF FATHER Rex A Miller
11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)
12 MAIDEN NAME OF MOTHER Josephine Wumpford Boduchofen
13 BIRTHPLACE OF MOTHER (city or town) Iowa
(State or country)

14 Informant Paul Miller
(Address) Gooding Ida

15 Filled 10/31 19 26 J H Cronwall
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 8 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,
that I last saw him alive on _____, 19____,
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Stillborn
mother has diabetes
mel. (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____
Was there an autopsy? _____

What test confirmed diagnosis?
(Signed) J H Cronwall M. D.
10/31 1926 (Address) Gooding Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Gooding Date of Burial 10-8-1926

20. Undertaker W E Thompson Address Gooding

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton Mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Carcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic Interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

351126024-294
RECEIVED
 PLACE OF BIRTH **NOV 8 - 1926**

Form V. S. No. 11-C--25m-7-21-19

STATE OF IDAHO
 BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

County of Gooding
 City of Hagerman
 Registration District No. 2 File No. 146294
 No. _____ St. _____

Hospital _____ Primary Registration District No. _____ Registered No. _____

FULL NAME OF CHILD Lewis Larson

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legiti mate? <u>Yes</u>	Date of Birth <u>Oct 26</u> 19 <u>26</u> (Month) (Day) (Year)
--------------------------	---	-----------	--------------------------------	-------------------------	--

FULL NAME Leo Larson
 RESIDENCE Hagerman
 COLOR White AGE AT LAST BIRTHDAY 36 (Years)
 BIRTHPLACE Kansas
 OCCUPATION Farmer

FULL MAIDEN NAME Viviana Buelt
 RESIDENCE Hagerman
 COLOR White AGE AT LAST BIRTHDAY _____ (Years)
 BIRTHPLACE Utah
 OCCUPATION House wife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature) RH Greene MD
 (Physician or midwife)
 Stillborn at 3:30 PM
 (Born alive or stillborn)

Address Hagerman
 Filed Oct 27 1926 RH Greene
 Registrar

Dup of 1926-148003

RECEIVED NOV 8 1926

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of Gooding

Primary Registration District No. _____

City of Hagerman

(No. _____ St.)

File No. 55226

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lewis Larson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Oct261926

(Month)

(Day)

(Year)

7. AGE

Still born

IF LESS than 1 day

how many _____ ds. or

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
- (b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Leo Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Vivian Pruett

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R.H. Greene(Address) Hagerman

15.

Filed Oct 27 1926 R.H. Greene

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 26 - 1926

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended, deceased from

I born dead

that I last saw him alive on _____ 191 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Had been dead about 10 days before birth
Some kidney affection

Contributory (Secondary)

in mother

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R.H. Greene M. D.19 _____ (Address) Hagerman

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding
NoneOct 27 1926

20. UNDERTAKER

ADDRESS

—

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm-laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PL

RECEIVED OCT 27 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone

City of Blackfoot

No. 132121029-335 St.

Hospital

Registration District No.

File No.

Primary Registration District No.

Registered No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u> { and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>9-21-1926</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? None necessary

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 10

FATHER		MOTHER	
FULL NAME <u>Marvin Albright</u>	FULL MAIDEN NAME <u>Esther Clem</u>	FULL NAME <u> </u>	FULL MAIDEN NAME <u> </u>
RESIDENCE <u>Julietta</u>	RESIDENCE <u>Julietta</u>	RESIDENCE <u> </u>	RESIDENCE <u> </u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Moscow Idaho.</u>	BIRTHPLACE <u>Missouri</u>	BIRTHPLACE <u> </u>	BIRTHPLACE <u> </u>
OCCUPATION <u>Trucking</u>	OCCUPATION <u>Wf.</u>	OCCUPATION <u> </u>	OCCUPATION <u> </u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5:30 A. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

....., 19.....

Registrar.

(Signature)

Oliver J. Morehead M.D.
Physician
(Physician or midwife)

Address

Rendrick, Idaho
Filed Oct 1 1926 G. F. Walker
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. RECEIVED OCT 27 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Latah
City of Hendrick

Registration District No.

Primary Registration District No.

(No. St.)

State File No. 55258

Local Registrar's No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Albright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word)

6. DATE OF BIRTH

9-21-1926
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF
FatherMarvin Albright11. BIRTHPLACE
OF FATHER(State or Country) Idaho12. MAIDEN NAME
OF MOTHEREather Clem13. BIRTHPLACE
OF MOTHER(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Oliver J. Morehead M.D.
Hendrick, Ida.

15.

Filed

Oct 121926G. F. Walker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 31, 1926
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept 21, 1926 to 1926that I last saw him alive on 1926
and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Oliver J. Morehead M.D.(Address) Hendrick

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oct 21, 1926

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

NOV 15 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of MadisonCity of RexburgNo. 495 106 033 141Registration District No. 100State File No. 146446

Hospital

Registration District No. 7172Local Registrar's No. 1526

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?

}

and

{ Number
in order
of birth1Legiti-
mate?YesDate of
birth1061926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Silver nitrate 1%

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth 0FULL
NAME

FATHER

Louis Emmanuel DietelFULL
MAIDEN
NAME

MOTHER

Aola Adams

RESIDENCE

Rexburg

RESIDENCE

Rexburg

COLOR

White

AGE AT LAST

BIRTHDAY

25
(Years)

COLOR

White

AGE AT LAST

BIRTHDAY

25
(Years)

BIRTHPLACE

Rexburg

BIRTHPLACE

Rexburg, Idaho

OCCUPATION

Motion Picture Operator

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

M. D. Huthgund

(Physician or midwife)

Address

Rexburg, Ida.

Filed

11/10 1926

Registrar

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



2000-0004

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25-M. 1-19.

RECEIVED OCT 14 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Madison.

City of Rexburg.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. _____ St.)

State File No. 54943

Local Registrar's No. 322

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Dieterle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Babe.

(Write the word)

6. DATE OF BIRTH

October 6 1926

(Month) (Day) (Year)

7. AGE

Still Born.

IF LESS than 1 day how many
_____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Babe.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF

Father Louis Emmanuel Dieterle

11. BIRTHPLACE OF FATHER

(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER

Ada Adams.

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dieterle

(Address) Rexburg, Idaho.

15.

Filed 10/10

19 26

Local Registrar Ad E. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 6 1926

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-6 1926 to 10-6 1926

that I last saw h. _____ alive on _____ 19 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Rutherford, M. D.

10/6/1926 (Address) Rexburg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Rexburg, Idaho.

DATE OF BURIAL

10/7/26 19 _____

20. UNDERTAKER

ADDRESS

Rexburg,

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

493-217035-275
PLACE OF BIRTH RECEIVED OCT 29 1926

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. B. No. 11-6-24-3-3-17

S

County of Nez Perce
City of near Sweetwater Idaho

Registration District No. 128 File No. 146470

No. St.

Primary Registration District No. Caldwell vicinity Registered No.

Hospital

FULL NAME OF CHILD Stillborn Miles

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u> and { Number in order of birth <u> </u> }	Legitimate? <u>yes</u>	Date of Birth <u>10 17 26</u> (Month) (Day) (Year)
FULL NAME <u>Charles Miles</u>	FATHER	FULL MAIDEN NAME <u>Agnes Spencer</u>	MOTHER
RESIDENCE <u>Sweetwater Idaho.</u>		RESIDENCE <u>Sweetwater Idaho.</u>	
COLOR <u>Indian</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)	COLOR <u>Indian</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Idaho.</u>		BIRTHPLACE <u>Idaho.</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9:10 A.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) George Guignard
Physician
(Physician or midwife)

Given names added from a supplemental report.

Address Caldwell Idaho.

.....19.....

Filed Oct 26 1926 George Guignard
Registrar

Registrar

Registrar

RECEIVED OCT 28 1926
 1. PLACE OF DEATH *Big Pine*
 Registration District No. *128*
 County of *Big Pine* Primary Registration District No. *Culdesue &*
 City of *Culdesue Idaho* (No. *Vicinity* St.)
 If death occurs away from usual residence, give facts called for under special information.
 2. FULL NAME *Stillborn Miles*
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *55300*
 Registered No. _____
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Indian* 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

10 *17* *1926*
 (Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
 how many ____ hrs.
 or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho.*

10. NAME OF FATHER

Charles Miles

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho.*

12. MAIDEN NAME OF MOTHER

Agnes Spencer

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs Charles Miles*(Address) *Sweetwater Idaho.*

15.

Filed *Oct* 19 *26**George Gagnard*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 *17* *1926*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

____ 19____, to ____ 19____

that I last saw him alive on ____ 19____,

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH was as follows:

Stillborn

____ (Duration) ____ Yrs. ____ mos. ____ ds.

Contributory
(Secondary)

____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

Oct 26 *George Gagnard* M. D.
 (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted
 if not at place of death?

Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

316-209035-296

RECEIVED OCT 20 1926

Form V. S. No. 11-0-22m-0-8-17

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

S

County of *Neyce*

CERTIFICATE OF BIRTH

City of *Hamden*Registration District No. *128*File No. *146480*

No.St.

Primary Registration District No.

Registered No.

Hospital

FULL NAME OF CHILD

Stillborn Lawrence

Sex of Child

*F*Twin
Triplet
or other?

and

(Number
in order
of birth)Legiti-
mate?*Yes*

Date of Birth

*10/9**26*

(Month) (Day) (Year)

FULL NAME

FATHER

Ossie Lawrence

FULL MAIDEN NAME

MOTHER

Ellen Broncheau

RESIDENCE

near Culdesac

RESIDENCE

near Culdesac

COLOR

Part Indian

AGE AT LAST BIRTHDAY

53

(Years)

COLOR

Part Indian

AGE AT LAST BIRTHDAY

32

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

*Housewife*Number of child of this mother, including present birth.....*2*.....Number of children of this mother now living, including present birth.....*0*.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was.....*Stillborn*.....
on the date above stated.

(Born alive or stillborn)

at *10:50 a.m.*

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

George Gagnier M.D.

(Physician or midwife)

Given names added from a supplemental report.

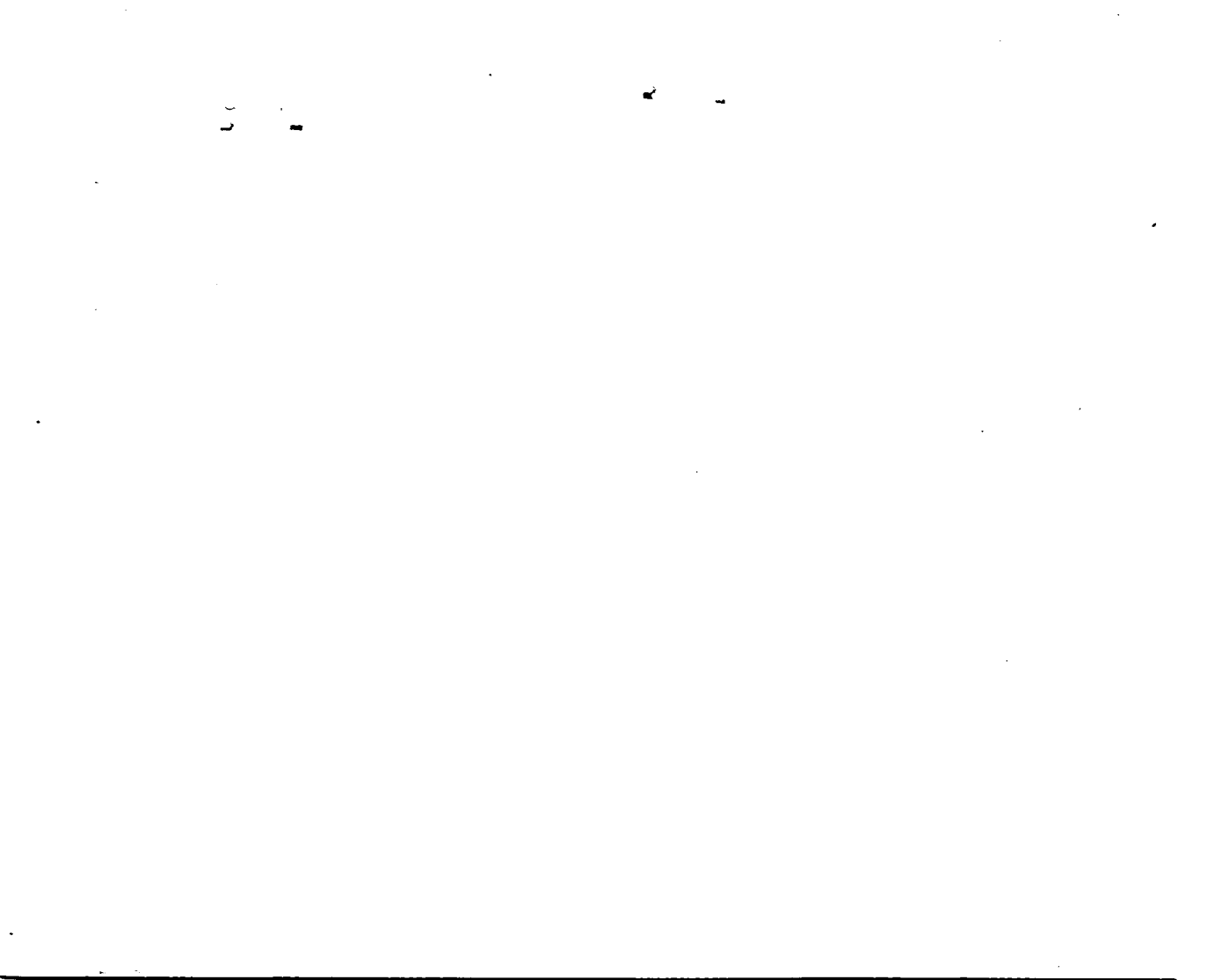
Address.....

Filed

10/16 1926 George Gagnier M.D.

Registrar

Registrar



RECEIVED OCT 28 1926

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 55299

Registered No. _____

1. PLACE OF DEATH

Registration District No. 128

County of Nez Perce

Primary Registration District No. Culelesae &

City of near Culelesae Idaho

(No. Vicinity

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Lawrence

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female Indian

(Write the word.)

6. DATE OF BIRTH

10
(Month)9
(Day)1926
(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Odie Lawrence

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho.

12. MAIDEN NAME OF MOTHER

Ellen Bronckhaus

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Oct 26 George Gaignard No. 1
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10
(Month)9
(Day)1926
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

George Gaignard M. D.
Oct 26 (Address) Culelesae Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

219-216-035-819
PLACE OF BIRTH

RECEIVED

NOV 8 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 146501

City of Lewiston

No. 331-2nd Ave St. Registration District No. 96 State File No. _____

Hospital _____ Primary Registration District No. 1009 Local Registrar's No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>M</u>	Twin Triplet or other? <u> }</u> and <u> {</u> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Oct 16</u> 192 <u>6</u> (Month) (Day) (Year)
-----------------------	--	------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME J. G. Barker
RESIDENCE 331-2nd Ave. Lewiston, Ida.
COLOR W. AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Iowa
OCCUPATION Auto Salesman

MOTHER
FULL MAIDEN NAME Mabel M. Hardy
RESIDENCE 331-2nd Ave. Lewiston, Ida.
COLOR W. AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Wash.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4-9 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1926

(Signature) J. M. Lyle

(Physician of Lewiston, Ida.)
Address _____

Filed Nov 6 1926 Susan E. Bruce Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—In case of more than one child at birth a SEPARATE RETURN must be made each and the number of each, in order of birth stated.

Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 8 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

55293

State File No.....

Local Registrar's No.....

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Preserve
City of Lewiston

Registration District No. 96
Primary Registration District No. 1409

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Border

(a) Residence. No. 331 1 2nd Ave St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Child

16 DATE OF DEATH Oct. 16 1926
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw h. _____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.

6 DATE OF BIRTH (month, day and year) 11

7 AGE Years Months Days 1 If LESS than 1 day, _____ hrs. or _____ min. Subborn

The CAUSE OF DEATH was as follows:
Stillborn
Transverse presentation
(duration) _____ yrs. _____ mos. _____ ds.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

9 BIRTHPLACE (city or town) Lewiston
(State or country)

18 Where was disease contracted
if not at place of death?

10 NAME OF FATHER Jamus G Border

Did an operation precede death? _____ Date of _____

11 BIRTHPLACE OF FATHER (city or town) Tenn
(State or country)

Was there an autopsy? no

12 MAIDEN NAME OF MOTHER Mable M. Harney

What test confirmed diagnosis? _____

13 BIRTHPLACE OF MOTHER (city or town) Wash
(State or country)

(Signed) J. M. - Leggett M. D.

10-16- 1926 (Address) Lewiston

14 Informant J. G. Border
(Address)

19 Place of Burial, Cremation, or Removal Vassar Co Date of Burial Oct-16 1926

15 Filed Nov 4, 1926 Susan E Bruce
Registrar

20. Undertaker Lewiston Idaho Address Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED OCT 20 1926 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 146601

No. 70 St. Providence Registration District No. 121 State File No. 126
Hospital Providence Primary Registration District No. 121 Local Registrar's No. 126

FULL NAME OF CHILD Walter Raymond Marsh
(Certificate of no value without full name of child)

Sex of Child M Twin Triplet or other? and { Number in order of birth 1 } Legitimate? Yes Date of birth 8-23-1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Cryosol

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Walter Marsh
RESIDENCE Burke Ida
COLOR W AGE AT LAST BIRTHDAY 38
(Years)
BIRTHPLACE England
OCCUPATION Miner

MOTHER
FULL MAIDEN NAME Flora Walmley
RESIDENCE Burke Ida
COLOR W AGE AT LAST BIRTHDAY 39
(Years)
BIRTHPLACE England
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 8:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Dr. Howard
Physician
(Physician or midwife)
Address Walla Walla
Filed Sept 5 1926

Registrar.

CE 4



10-17-01

to
MI

10-17-01

to 10-17-01

10-17-01

10 D

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

763 227040-263

PLACE OF BIRTH

RECEIVED OCT 20 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone

City of Wallace

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 7 State File No. 146606

Hospital Providence Primary Registration District No. 1011 Local Registrar's No. 111

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child 7 Twin Triplet or other? 1 and { Number in order of birth } Legitimate? Yes Date of birth 8-27- 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 0

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Otto Potts
RESIDENCE Wallace Ida
COLOR W AGE AT LAST BIRTHDAY 41
(Years)
BIRTHPLACE Calif
OCCUPATION Dairymen

MOTHER
FULL MAIDEN NAME Bessie Solum
RESIDENCE Wallace Ida
COLOR W AGE AT LAST BIRTHDAY 27
(Years)
BIRTHPLACE Wiax
OCCUPATION House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Wallace Ida

10/20/26 1926

Registrar.

Registrar.

Article added to report in April 1960 re: "The Role of the State in Economic Development"

These names were a confidential report.

I hereby certify that I attended the trial of
on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

in 1961, I met a man who was a member of the group. I met him at the time he was in the group. I met him at the time he was in the group. I met him at the time he was in the group.

Page 11 of 11

2021/11/16

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SECRET

NOTA 9020

30A-194118

COPIES

ACME CORP

WANT

REPLY

Number of child in this school, including those in special classes:

REFERENCE

44-38861-1000

MENTOM

EXAMPLE

COLORED

20140112

AGE AT LAST
BIRTHDAY

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

100

Large ni bozu

CLINT MARY JUNE

183/9201

04

to read

(To be answered only if asked in print phase)

Figure 1

in detail:

(this is not the case of child)

RECEIVED SEP 16 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **54991**

PLACE OF DEATH

County of Shoshone
City of WallaceRegistration District No. 70Primary Registration District No. 101(No. Providence Hospital)Local Registrar's No. 25

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant of Otto F. Petto(a) Residence. No. About 1 mile east of Wallace on Canyon Creek

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓6 DATE OF BIRTH (month, day and year) August 27 19267 AGE Still born Years Months Days 1 If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓(b) General nature of industry, business, or establishment in which employed (or employer) ✓(c) Name of employer ✓9 BIRTHPLACE (city or town) Wallace Idaho
(State or country)10 NAME OF FATHER Otto F. Petto11 BIRTHPLACE OF FATHER (city or town) California
(State or country)12 MAIDEN NAME OF MOTHER Bessie Irene Solari13 BIRTHPLACE OF MOTHER (city or town) Wisconsin
(State or country)14 Informant Otto F. Petto
(Address) Wallace Idaho15 Filed Aug 27, 1926 Registrar Bruce G. Norstrom

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 27 1896
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

that I last saw him alive on _____, 19____, and that death occurred on the date stated above, at 4 P m.The CAUSE OF DEATH was as follows: Still born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) None

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) D. M. W. P. M. D.19 Place of Burial, Cremation, or Removal Wallace, IdahoDate of Burial 8-29-192620. Undertaker Bruce G. Norstrom Address Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED NOV 6 - 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

914 711 441-393

County of Teton

City of Teton

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 77 State File No. 146678

Hospital _____ Primary Registration District No. 2176 Local Registrar's No. 41

FULL NAME OF CHILD Infant Rammell

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth 10-11-1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 12 Number of child of this mother now living, including present birth 9

FATHER
FULL NAME Alma H. Rammell
RESIDENCE Teton, Ida.
COLOR W. AGE AT LAST BIRTHDAY 46
(Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Nora Little
RESIDENCE Teton
COLOR W. AGE AT LAST BIRTHDAY 42
(Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 2:15 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Emily J. Beesley
Midwife
(Physician or midwife)

Address Driggs, Idaho

Filed 11-9-1926 Martha Marker

Registrar.

Registrar.

I hereby certify that I attended the birth of this child, who was born at _____
 on the _____ day of _____, 19____, at _____
 and that the child is now living.

CERTIFICATE OF BIRTH

Hospital _____ Physician Registration District No. _____ State _____	
(Certification of no living children (full name of child)) _____	
Date of birth _____ (Month) (Day) (Year)	Sex _____ (Male) (Female)
What medical condition was used in case? _____	
Name of child of the mother, including given name and surname _____	
FATHER Name _____ Surname _____ Color _____ Birth place _____ Occupation _____	MOTHER Name _____ Surname _____ Color _____ Birth place _____ Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at _____
 on the _____ day of _____, 19____, at _____
 and that the child is now living.

When there was an attending physician or midwife, name the name, residence, and address of the attending physician or midwife. Is the name, address, residence and occupation of the other party? _____

Address _____
 City _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M

RECEIVED NOV 6 1926

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Teton
City of Teton R.D.Registration District No. 77Primary Registration District No. 2176

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

InfantState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 55341Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Oct-11-1926
(Month) (Day) (Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country)

(Idaho

10. NAME OF FATHER

Alma H. Rammell

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Nora Little

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Alma H. Rammell

(Address)

Teton R.D. Idaho

15.

Filed 10-12-1926Martha Mark

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 11 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw him alive on 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. da.

Contributory
(Secondary)Dont know

(Duration) yrs. mos. ds.

(Signed)

Annie J. Kusley, midwife

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Teton, Ida10-11-1926

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED NOV 12 1926 STATE OF IDAHO
619-101 042 248 DEPARTMENT OF PUBLIC WELFARE
County of Lewin Falls. BUREAU OF VITAL STATISTICS
City of Lewin Falls. CERTIFICATE OF BIRTH
No. _____ St. Registration District No. 37 State File No. 146688
Hospital L. T. County General Primary Registration District No. 1085 Local Registrar's No. _____
FULL NAME OF CHILD John Thomas Farmer, Jr.
(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>Nov. 1</u> 192 <u>6</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>2</u> Number of child of this mother now living, including present birth <u>1</u>			
FULL NAME <u>John Thomas Farmer</u>	FATHER	FULL MAIDEN NAME <u>Bess C. Kuhns.</u>	MOTHER
RESIDENCE <u>Amsterdam Ida.</u>		RESIDENCE <u>Amsterdam</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Lucerne Mo.</u>		BIRTHPLACE <u>Winston Mo.</u>	
OCCUPATION <u>Farming</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was { Stillborn } at 1000 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, mother, or other person, should make this report. If the child is one that neither father nor mother shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1926

(Signature) H. E. Lamb

(Physician or midwife)

Address J. J.

Filed 11-10

1926

Registrar.

Registrar.

OFFICE OF THE DIRECTOR

1986 Local Registrar's No. 1086

CHILD ABUSE OR CHILD

(Certificate of no value without FBI name of child)

[Faint header information at the top of the page, mostly illegible.]

Large # of new war materiel introduced into

None of the mother, including breast milk.

Number of child of this mother and father to child to mother

PATMER

NAME
MADON
LUL

ЯЗНТОМ

000000

YACHTIN

NOT ON

YACHTING

[illegible]

DECLASSIFIED

OCCUPATION

OPTION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I further certify that I attended the birth of this child, who was [redacted]

10-10-68

shows other evidence of the effect of
this is one that might be
etc. should make this rather
or, while from the fact
* When there was no attack
physician

(S15704312)

(b)(7)(D) - (b)(7)(F)

805755A

help

100

RECEIVED NOV 12 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 55346

PLACE OF DEATH

County of Twin FallsCity of Twin Falls

CERTIFICATE OF DEATH

Registration District No. 37Primary Registration District No. 1085(No. Twin Falls County Hospital)

Local Registrar's No. _____

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant John Thomas Farmer
(Address) Amsterdam Idaho15 Filed 11-10, 1926 John F. Laughlin
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

11 1 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Still born, 19____, to _____, 19____.

that I last saw h. _____ alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) H. C. Lamb, M. D.

_____, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Twin Falls Nov 2 1926

20. Undertaker

Address

Paul Beer Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

NOV 2

1925

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Laramie

City of Allen

No. 959-208-042862

Registration District No. 38

State File No. 146728

Hospital

Primary Registration District No. 2086

Local Registrar's No.

FULL NAME OF CHILD

Not N.

(Certificate of no value without full name of child)

Sex of Child

G.

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

Oct. 8

1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Agno 3 1%

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

6

FULL
NAME

FATHER

Herman Reinde

RESIDENCE

Buhl Ida

COLOR

W.

AGE AT LAST
BIRTHDAY

47
(Years)

BIRTHPLACE

Nebr.

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Helene Hobelmann

RESIDENCE

Buhl Ida

COLOR

W.

AGE AT LAST
BIRTHDAY

39
(Years)

BIRTHPLACE

Nebr.

OCCUPATION

Styfe

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 2 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 1926

(Signature)

A. A. Newberry

(Physician or midwife)

Address

Filed

Oct 8 1926

aan.

Registrar.

Registrar.

PLACE OF BIRTH

RECEIVED NOV 8 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of J. F.City of BuhlNo. 955-223042-168 St.

Registration District No.

State File No.

146741

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

FemaleTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?YesDate of
birth10-23-1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

erythrol

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

Vernon Loverson

RESIDENCE

Buhl

COLOR

whAGE AT LAST
BIRTHDAY26

(Years)

BIRTHPLACE

Utah

OCCUPATION

farmerFULL
MAIDEN
NAME

MOTHER

Thelma Johnson

RESIDENCE

Buhl

COLOR

whAGE AT LAST
BIRTHDAY24

(Years)

BIRTHPLACE

Idaho

OCCUPATION

H.W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 9 P. M.
on the date above stated.*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Dr. Jennings

(Physician or midwife)

Address

Buhl, Ida.

Filed

192

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

2

NO. 1000

STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS

Registration District No. 100
City of New York
Borough Registration District No. 100

(Certificates of no value without full name of child)

Age at birth 10 months 10 days
Date of birth 10-10-10
Year 1910

What additional notation is used in event

Number of child of this mother and living issue at present date

Number of child of this mother, including previous birth

FULL
NAME
MOTHER

FATHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

COLOR

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

(Signature)

Give names and date of additional report
showing cause of death of child
child was born at home
and was attended by a physician
who gave me no attending physician
or midwife (check the latter)
or midwife (check the latter)
or midwife (check the latter)
or midwife (check the latter)

(Signature of midwife)

Address

100

100

100

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Twin FallsCity of Buhl

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME Baby IversonRegistration District No. 39Primary Registration District No. 2087(No. 3 St.)

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

State File No. 55367

Local Registrar's No. _____

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle

(Write the word)

6. DATE OF BIRTH

Oct 23 1926

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1
 day how many

hrs. or

min.?

Yrs.

Mos.

ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of workNone(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Buhl, Ida.

10. NAME OF

Father

Vernon Iverson

11. BIRTHPLACE

OF FATHER

(State or Country)

Utah

12. MAIDEN NAME

OF MOTHER

Selma Johnson

13. BIRTHPLACE

OF MOTHER

(State or Country)

Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Vernon Iverson

(Address)

Buhl, Ida.

15.

Filed 10-241926

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-23 1926 to 10-23 1926that I last saw him alive on 10-23 1926and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH was as follows:

Still born - due to
premature detachment
of placenta.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

10-24 1926

*State the Disease Causing Death; or in deaths from Violent
 Causes, state (1) Means of Injury; and (2) whether Accidental,
 Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
 of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl, Ida

DATE OF BURIAL

10-24-1926

20. UNDERTAKER

ADDRESS

BUHL, IDA.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

RECEIVED NOV 29 1926

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada

City of Star

No. 364-107.001-316 St.

Registration District No. 9+10

File No. 146869

Hospital

Primary Registration District No. 9+10

Registered No. ✓

FULL NAME OF CHILD

James Couzens
(Certificate of no value without full name of child.)

Sex of Child

M

Twin
Triplet
or other?

{ and }

{ Number
in order
of birth }

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

11-7
(Month) (Day)

1926
(Year)

What bactericidal solution was used in eyes?

no

Number of child of this mother, including present birth

3

Number of child of this mother now living, including present birth

3

FULL
NAME

FATHER

Marquart Couzens

FULL
MAIDEN
NAME

MOTHER

Minnie Lawrence

RESIDENCE

Star Idaho

RESIDENCE

Star Idaho

COLOR

W

AGE AT LAST

32
BIRTHDAY (Years)

COLOR

W

AGE AT LAST

47
BIRTHDAY (Years)

BIRTHPLACE

Utah

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was
on the date above stated.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Stap Idaho 7309 M.
(Born alive or stillborn)
Oliver M. M.

(Physician or midwife)

Give names added from a supplemental report.

Address

Star Idaho

Filed

Nov 15 1926

Oliver M. M.

Registrar.

Registrar.

602

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED NOV 25 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of *Bear Lake*

City of *Montpelier*

CERTIFICATE OF BIRTH

No. *112004395* St. Registration District No. *83* State File No. *146960*

Hospital _____ Primary Registration District No. *2136* Local Registrar's No. _____

FULL NAME OF CHILD *Baby Jordan (not named)*
(Certificate of no value without full name of child)

Sex of Child *Male* Twin Triplet or other? _____ and { Number in order of birth _____ Legitimate? *yes* Date of birth *Sept 12* 192*6*
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth *3* Number of child of this mother now living, including present birth *1*

FATHER
FULL NAME *Leon M. F. Jordan*
RESIDENCE *Cokeville Wyo*
COLOR *White* AGE AT LAST BIRTHDAY *41* (Years)
BIRTHPLACE *Italy*
OCCUPATION *Presbyterian Minister*

MOTHER
FULL MAIDEN NAME *Edua Linstrom*
RESIDENCE *Cokeville Wyo*
COLOR *White* AGE AT LAST BIRTHDAY *39* (Years)
BIRTHPLACE *Minn.*
OCCUPATION *Cope*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was { *Stillborn* } at *10 30* *9* M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) _____

(Physician or midwife)

Address _____

Filed _____

Registrar.

Registrar.

Copy

RECEIVED WITH ATTACHED COPY

TO BE KEPT IN FILE OF ALL INFORMATION

DATE

1955

Respectfully,
The names added to the accompanying report
show other members of the family
and a health record of the
family from the time the
report was made to the
present time and on the date
of the report.

I hereby certify that the above is a true and correct copy of the original report as it appears in the files of the Bureau of the Census.

DEPARTMENT OF ATTENDING PHYSICIAN OR MIDWIFE

OCCUPATION

AGE

SEX

RESIDENCE

NAME

CATHERINE

CHILD

RESIDENCE

COLOR

TELEPHONE
VACATION

(over)

R

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED NOV 23 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bear Lake

City of Montpelier

No. 331 222-004 444 St.

Registration District No. 3

State File No.

Hospital

Primary Registration District No. 2136

Local Registrar's No.

CERTIFICATE OF BIRTH

146968

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

female

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

Oct 22

1926

(To be answered only in event of plural births)

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth

4

Number of child of this mother now living, including present birth

2

FULL
NAME

FATHER

Royal D Clark

FULL
MAIDEN
NAME

MOTHER

Mary E Mumford

RESIDENCE

Montpelier Idaho

RESIDENCE

Montpelier Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

34
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

35
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Utah

OCCUPATION

Merchant

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~born alive~~ Stillborn at 6 a. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

Corcoran M. D.

(Physician or midwife)

Address

Paris Idaho

Filed

11/20/1926

1926

Registrar.

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2

WILLIAMS

STATE OF ILLINOIS

State of Illinois, County of Cook, ss. I, the undersigned, Clerk of said County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of said County.

(Certified to be a true and correct copy of the original as the same appears in the records of said County.)

Date of birth (mm/dd/yyyy)
Place of birth (city, state, and country)
Sex (M/F)

Number of children born to mother, including present child.

MOTHER

FULL
MAIDEN
NAME

FATHER

AGE AT LAST
BIRTHDAY

COLOR

AGE AT LAST
BIRTHDAY

BUILD

OCCUPATION

OCCUPATION

DATE OF ATTENDING PHYSICIAN OR MIDWIFE

The birth of this child was attended by

(Signature)

There was no attending physician or midwife present at the birth of this child. A statement of the mother's previous pregnancies and the date of each birth is attached to this report.

ADD 222

THE

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. MEANT OF OCCUPATION is very important. See instructions on back of certificate.

PHYSI-
act state-

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

County of Beau Lake

Primary Registration District No. 2136

City of Montpelier

(No. _____ St.)

File No. 57116

Registered No. _____

death occurs away from usual residence, give facts called for under "Cause of Death" information.

2. FULL NAME

Baby Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single

(Write the word.)

6. DATE OF BIRTH

Stillborn birth
Oct 22 1926

(Month)

(Day)

(Year)

7. AGE

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Royal D Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary E Mumford

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Deerwood

(Address)

Paris Idaho

15.

Filed

April 21 1927

1927

M. King

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

22

1926

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191...., to

191....

that I last saw h. alive on

191....

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Stillborn - female - 8 1/2 mos
Oct 22 1926

Cause Unknown

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

C. O. Moore

M. D.

10/22/1926 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

.....yrs.mos.days.

In the

State

.....yrs.mos.days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Montpelier Idaho Oct 23 1926

20. UNDERTAKER

ADDRESS

W. H. Williams Montpelier Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

249-220005-236

PLACE OF BIRTH

RECEIVED DEC 3 - 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

146985

County of Bennett

City of Desmet

No. _____ St. _____

Registration District No. 91

File No. _____

Hospital _____

Primary Registration District No. _____

Registered No. 13

FULL NAME OF CHILD Unnamed Infant

(Certificate of no value without full name of child.)

Sex of Child <u>f.</u>	Twin Triplet or other? _____ and (Number in order of birth) _____	Legitimate? <u>yes</u>	Date of birth <u>Nov. 20</u> 19 <u>26</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth... 1... Number of children of this mother now living, including present birth... 1...

FULL NAME <u>Harvey Edward Smith</u>	FATHER
RESIDENCE <u>Desmet</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Alberta, Canada</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Edith Scott</u>	MOTHER
RESIDENCE <u>Desmet</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Emida, Idaho</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born at Desmet on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. E. Huggler, Jr.
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address Desmet, Idaho
Filed Nov. 22 1926
John Post Registrar

2
JANUARY 1951

1951
JAN

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **55447**

1. PLACE **RECEIVED DEC 3 - 1926**
Registration District No.
County of *Bismarck* Primary Registration District No.
City of *Desmet* (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed Infant

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female *white* *single* (Write the word.)

6. DATE OF BIRTH

Nov *20* *1926*
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Desmet Ida*

10. NAME OF FATHER

Harvey Edward Smith

11. BIRTHPLACE OF FATHER

(State or Country) *Alberta Canada*

12. MAIDEN NAME OF MOTHER

Edith Scott

13. BIRTHPLACE OF MOTHER

(State or Country) *Emida Ida*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. E. Abegglen

(Address)

Desmet

15.

Filed *Nov. 20* *1926*

John Post
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. *20* *1926*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillborn

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed)

*W. E. Abegglen**Nov 20* *1926*

(Address)

Desmet

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Desmet

DATE OF BURIAL

Nov. 20 *1926*

20. UNDERTAKER

Harvey E. Smith

ADDRESS

Desmet, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*; *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated, unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH **RECEIVED DEC 2 - 1926** STATE OF IDAHO
695-2113010-755
DEPARTMENT OF PUBLIC WELFARE
County of Bonneville
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH **147105**

No. _____ St. _____ Registration District No. 23 State File No. _____
Hospital LAB. Primary Registration District No. 2145 Local Registrar's No. 421

FULL NAME OF CHILD (Stillborn) Field
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Nov 11</u> 192 <u>6</u> (Month) (Day) (Year)
-------------------------------	---	--------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME A. C. Field
RESIDENCE Idaho Falls RD 5
COLOR White AGE AT LAST BIRTHDAY 50 (Years)
BIRTHPLACE Ogden Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Sarah A. Pennock
RESIDENCE Idaho Falls RD 5
COLOR White AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Rigby Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 730 A M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. G. Anderson M.D.
(Physician or midwife)

Address Rigby Idaho
Filed Nov 13 1926 Benjamin
Registrar. Registrar.

Added to table in 11-28-41 to redetermine cost of new design

RECEIVED
BUREAU OF MIAMI
DEPARTMENT OF JUSTICE
JAN 10 1964

Continued

100-443881-10

[illegible]

It is to be answered only in event of actual failure

Number of child of this mother now living in United States birth

ЯЗНТОМ

FATHER

ENCLOSURE

SECRET

॥०॥

1992

20. 1941

304 JPH/ACE

NOTES

Q. Now, you said that you didn't know who the father of this child was, is that right?

(Pittman and Pittman)

॥ श्रीगणेशाय नमः ॥

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED DEC 7 1926

PLACE OF BIRTH

141-227-016-981
County of Cassia

City of Nat

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 147178

No. _____ St. _____ Registration District No. 119 State File No. _____

Hospital At home Primary Registration District No. 2198 Local Registrar's No. _____

FULL NAME OF CHILD Sophia Irene Adams
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? — and { Number in order of birth — } Legitimacy yes Date of birth Nov 27 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 8

FATHER
FULL NAME Frank Adams
RESIDENCE Nat Idaho
COLOR White AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Germany
OCCUPATION Farmers

MOTHER
FULL MAIDEN NAME Irene Louise Ryan
RESIDENCE Nat Idaho
COLOR White AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Helton Utah
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:38 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) C. J. Sauer, M.D.

(Physician or midwife)
Address Malta Idaho
Filed Dec 3 1926 C. J. Sauer

Registrar.

Registrar.

THIS IS TO CERTIFY THAT THE CHILD OF THE NAME OF _____ BORN _____ AT _____ IN THE COUNTY OF _____ STATE OF _____ WAS BORN TO _____ AND _____ AND WAS BORN AT _____ IN THE COUNTY OF _____ STATE OF _____

STATE OF _____
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____

Primary Registration District No. _____

(Certificate of no value without full name of child)

Child's Name _____ Sex _____
Date of Birth _____
Month _____ Year _____
Time of Birth _____
Place of Birth _____
To be completed only in case of stillbirth

What pathological condition was noted in case?

Number of child in the family, including present birth _____
Number of child to this mother now living, including present birth _____

FATHER FULL NAME _____
MOTHER FULL NAME _____

RESIDENCE _____

COLOR _____ AGE AT LAST BIRTHDAY _____

BIRTHPLACE _____

OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____ on the date above stated.

When there was no attending physician or midwife, then the doctor, nurse, or other person who attended the birth, should make this return. A stillborn child is one that neither cries nor shows other evidence of life after birth. Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address _____

City _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 8 1926

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

County of Cassia
City of Nat

Registration District No. 119Primary Registration District No. 2198

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sophia Irene Adams

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5560

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female White Single
(Write the word.)

6. DATE OF BIRTH.

Nov 27 1926
(Month) (Day) (Year)

7. AGE

still born

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Nat Idaho

10. NAME OF FATHER

Frank Adams

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Irene L Ryan

13. BIRTHPLACE OF MOTHER

(State or Country)

Kelton Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Frank AdamsNat Id

15.

Filed

Jan 1 27 1926
C. P. Owen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 27 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

No 191, to No 191,
that I last saw h. at alive on 191.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

still born - Cause unknown. Probably compression of umbilical cord

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) B. J. Luter M. D.1926 (Address) Maeta Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nat IdahoNov 29 1926

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL, peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

365-724-819-188
PLACE OF BIRTH

RECEIVED DEC 10 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Custer

City of Challis

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 128 State File No. 147186

Hospital _____ Primary Registration District No. 2186 Local Registrar's No. 111

FULL NAME OF CHILD not named

(Certificate of no value without full name of child)

Sex of Child <u>M</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>not yet</u> 192 <u>6</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 8

FATHER
FULL NAME Geo. E. Loveland
RESIDENCE Challis Idaho
COLOR wh AGE AT LAST BIRTHDAY 46 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Emma Johnson
RESIDENCE Challis Idaho
COLOR wh AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

Removed from Dead mother
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 11 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. S. Hartley MD

(Physician or midwife)

Address Challis, Idaho

Filed Nov. 29 1926 Edna M. Kenney

Registrar.

Registrar.

UNITED STATES DEPARTMENT OF JUSTICE
BUREAU OF PRISONS
(FEDERAL BUREAU OF INVESTIGATION)

INVESTIGATION OF CHILD
Name of Child: _____
Date of Birth: _____
Place of Birth: _____
Sex: _____
Color: _____
Height: _____
Weight: _____
Build: _____
Hair: _____
Eyes: _____
Skin: _____
Tattoos: _____
Scars: _____
Other: _____

Wanted for _____
Reason: _____
Arrested: _____
Where: _____
By: _____
Date: _____
Judge: _____
Sentence: _____
Term: _____
Parole: _____
Release: _____
Other: _____

Family History: _____
Parents: _____
Siblings: _____
Other: _____
Address: _____
City: _____
State: _____
Zip: _____
Phone: _____
Other: _____

Education: _____
Occupation: _____
Employer: _____
Income: _____
Expenses: _____
Assets: _____
Liabilities: _____
Other: _____

Medical History: _____
Illnesses: _____
Injuries: _____
Operations: _____
Medications: _____
Allergies: _____
Other: _____

Character: _____
Mental: _____
Physical: _____
Moral: _____
Social: _____
Other: _____

Signature: _____
Date: _____
Address: _____
City: _____
State: _____
Zip: _____
Phone: _____
Other: _____

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/BJS

55588

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

CERTIFICATE OF DEATH

County of *Blaine*Registration District No. *108*City of *St. Paul*Primary Registration District No. *2186*

(No. St.)

File No. *2*Registered No. *49*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Loveland

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

1896

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Nov 23

(Month)

(Day)

1926
(Year)

7. AGE

Stillborn

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Challis, Ida

10. NAME OF FATHER

Geo. E. Loveland

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Emma Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. E. Loveland

(Address)

Challis, Ida

15.

Filed *Nov 29* 1926*Edna M. ...*
Local Registrar

16. DATE OF DEATH

Nov 23

(Month)

(Day)

1926
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 22, 1926, to Nov 23, 1926

that I last saw him alive on 19

and that death occurred on the date stated above, at *3 P* M.

The CAUSE OF DEATH* was as follows:

mother died before birth of child from hemorrhage due to placenta praevia

(Duration) Yrs. mos. ds.

Contributory (Secondary) *Child removed after death of mother*

(Duration) yrs. mos. ds.

(Signed) *E. L. Purley* M. D.19 (Address) *Challis, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Challis, Idaho

DATE OF BURIAL

Nov 26, 1926

20. UNDERTAKER

Friends

ADDRESS

Challis, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIVED DEC 6 - 1926
369 228 021 235
County of Franklin
City of Preston
No. _____ St. Registration District No. 27 State File No. 147210
Hospital _____ Primary Registration District No. 2117 Local Registrar's No. 269
FULL NAME OF CHILD Sylvester
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? } and { Number in order of birth } Legitimate? Yes Date of birth Nov. 28, 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 9		Number of child of this mother now living, including present birth 4	
FATHER FULL NAME Sylvester Lorin Corbridge		MOTHER FULL MAIDEN NAME Effie Stevens	
RESIDENCE Preston, Idaho		RESIDENCE Preston, Idaho	
COLOR White	AGE AT LAST BIRTHDAY 45 (Years)	COLOR White	AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Idaho		BIRTHPLACE Idaho	
OCCUPATION Farming		OCCUPATION Housewife	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Sylvester at 9:45 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Physician
(Physician or midwife)

Address Preston, Idaho

Filed Dec. 2, 1926

Registrar.

Registrar.

2

STATE OF IOWA
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF BIRTH

Registration Number No. _____
Primary Registration District No. _____

CHILD NAME OR NAME

(For purpose of the value of child)

Sex _____
Date of Birth _____
Place of Birth _____
(To be answered only in case of birth)

Month _____
Day _____
Year _____

What certificate of registration was used in case of _____

Number of children ever born, including present birth _____

FATHER _____
MOTHER _____

RESIDENCE _____

COLOR _____

AGE AT LAST BIRTHDAY _____

BIRTHPLACE _____

OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was delivered at _____

on the _____ day of _____

When there was no attending physician or midwife, then the father, householder, or another person, make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature of midwife)

Address _____

Phone _____

FORM V. S. RECEIVED

DEC 6 - 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of FranklinRegistration District No. 27City of PrestonPrimary Registration District No. 2119

(No. _____ St.)

State File No. 55589Local Registrar's No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn -- Baby Corbridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
Single

(Write the word)

6. DATE OF BIRTH

Nov. 28, 1926

(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?0 Yrs. 0 Mos. 0 ds. 0

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF

Father Sylvester Lorin Corbridge

11. BIRTHPLACE

OF FATHER Idaho

(State or Country)

12. MAIDEN NAME

OF MOTHER Ettie Stevens

13. BIRTHPLACE

OF MOTHER Idaho

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lorin Corbridge,(Address) Preston, Idaho

15.

Filed Dec. 2 1926 G. R. Under

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 28, 1926

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19,that I last saw him alive on 19,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn
Cause not known

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. R. Under M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death In the
yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston, Idaho

DATE OF BURIAL

11-28 1926

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, Foreman, Manager, Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**"); **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia,**" unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, Anaemia**" (merely symptomatic), "**Atrophy, Collapse, Coma, Convulsions, Debility, Congenital, Senile, etc., Dropsy, Exhaustion, Heart Failure, Hemorrhage, Inanition, Marasmus, Old age, Shock, Uraemia, Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		RECEIVED NOV 19 1926		STATE OF IDAHO		S
249-228-022-693				DEPARTMENT OF PUBLIC WELFARE		
County of <u>Freemont</u>				BUREAU OF VITAL STATISTICS		
City of <u>St. Anthony</u>				CERTIFICATE OF BIRTH		147228
No.	St.	Registration District No. <u>99</u>	State File No.			
Hospital		Primary Registration District No. <u>2177</u>		Local Registrar's No. <u>581</u>		
FULL NAME OF CHILD						
(Certificate of no value without full name of child)						
Sex of Child <u>female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Oct 28</u> 192 <u>6</u> (Month) (Day) (Year)		
What bactericidal solution was used in eyes?						
Number of child of this mother, including present birth <u>4</u>		Number of child of this mother now living, including present birth <u>3</u>				
FULL NAME FATHER <u>Lytle M. Smith</u>		FULL MAIDEN NAME MOTHER <u>Adam Williams</u>				
RESIDENCE <u>St. Anthony</u>		RESIDENCE <u>St. Anthony</u>				
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)	COLOR <u>white</u>		AGE AT LAST BIRTHDAY <u>35</u> (Years)		
BIRTHPLACE <u>Morgan Ut.</u>		BIRTHPLACE <u>Morgan Ut.</u>				
OCCUPATION <u>Stock Buyer</u>		OCCUPATION <u>Housewife</u>				
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE						
I hereby certify that I attended the birth of this child, who was { <u>born alive</u> } { <u>born dead</u> } { <u>macerated</u> } on the date above stated. { <u>born</u> } { <u>at</u> } <u>11</u> P. M.						
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.		(Signature) <u>J. Allison</u>				
Give names added from a supplemental report., 192....				(Physician or midwife)		
....., 192....		Address				
Registrar.		Filed <u>11/12</u> 192 <u>6</u>		<u>W. M. Hansen</u> Registrar.		

Don

1 17721-13

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED DEC 11 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Jefferson

City of Hailey

No. 884-221-026-759

St. Registration District No. 98

State File No. 147283

Hospital

Primary Registration District No. 2176

Local Registrar's No. 217

FULL NAME OF CHILD Stiehlborn

(Certificate of no value without full name of child)

Sex of Child F

Twin
Triplet
or other?

}

and {

Number
in order
of birth

Legiti-
mate? yes

Date of
birth 10/21

1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 7

Number of child of this mother now living, including present birth 4

FULL
NAME

FATHER

Bert Hymas

RESIDENCE

W. of Hailey

COLOR W

AGE AT LAST
BIRTHDAY 40

(Years)

BIRTHPLACE

Wash

OCCUPATION

Rancher

FULL
MAIDEN
NAME

MOTHER

Mary Perry

RESIDENCE

Same

COLOR W

AGE AT LAST
BIRTHDAY 34

(Years)

BIRTHPLACE

Wash

OCCUPATION

House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at A M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Earl L. Jones

(Physician or midwife)

Address Roberts

Filed 12/10 1926

Registrar.

Registrar.

PLEASE REFER TO ENTRY IN ALBUM TO 1948 AND 1949

1945-1946
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(9715512)

(Physical or Mental)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

HOITATUENDO

BOALINTH

TABLE
YACHTING

Color

DATE AT 1.021
BIRLINDAY

NAME

REPORT

NAME
MAIDEN
FULL

MEMORANDUM

Members of staff at this school, including person fifth

Number of child of the mother now living and residing in same birth

Large oil barrel with rubber laboratory taff

(added to file to move as also being used in)

10 295

100-44388-100

It is a
very
small

1979-80
1980-81

1945

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

(Declaration of no value without full name of child)

Latko #019

Registration District No. _____ State, File No. _____

883 71 17TH TO 27TH STREET

BUCHANAN & VITAL ST. LOUIS

RECEIVED DEC 11 1926

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **55613**
Registered No. **63**

1. PLACE OF DEATH

Jefferson
County of *Jefferson*
City of *Boise*

Registration District No. *98*
Primary Registration District No. *2176*
(No. *St.*)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Shelborn Hymas Bailey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *7* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Oct. 21 1926
(Month) (Day) (Year)

7. AGE

Shelborn
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Thor Hauer Ida

10. NAME OF FATHER

Bert Hymas

11. BIRTHPLACE OF FATHER

(State or Country)

Idah

12. MAIDEN NAME OF MOTHER

Mary Perry

13. BIRTHPLACE OF MOTHER

(State or Country)

Idah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bert Hymas

(Address)

Hauer, Ida

15.

Filled

12/10 1926 Ray Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 21 26
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...
that I last saw him alive on 19...
and that death occurred on the date stated above, at... M.
The CAUSE OF DEATH was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Earl Jones M. D.

1926 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Roberts Ida

DATE OF BURIAL

12/22 1926

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Jeff

City of new Hams

CERTIFICATE OF BIRTH

No. 268-129026993

St. Registration District No. 98

State File No.

147287

Hospital

Primary Registration District No. 2176

Local Registrar's No. 224

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of
Child

M

Twin
Triplet
or other?

}

and {

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

8/29

192

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

none

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

6

FULL
NAME

FATHER

Raymond Bohney

RESIDENCE

Camas

FULL
MAIDEN
NAME

MOTHER

Mary Emma Richardson

RESIDENCE

COLOR

W

AGE AT LAST
BIRTHDAY

45
(Years)

COLOR

W

AGE AT LAST
BIRTHDAY

35
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Rancher

OCCUPATION

House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9 A M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Earl Jones

(Physician or midwife)

Address

Roberts

Filed

12/10

1926

Ray Fisher

Registrar

Registrar.

COUNTY OF ... STATE OF ...
 I hereby certify that I attended the birth of this child, who was ...
 on the date above stated.
 When there was no attending physician or midwife, then the father, householder, etc. should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
 Give names added from a supplemental report.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ...
 on the date above stated.
 When there was no attending physician or midwife, then the father, householder, etc. should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
 Give names added from a supplemental report.

FATHER		MOTHER	
NAME	NAME	NAME	NAME
RESIDENCE	RESIDENCE	RESIDENCE	RESIDENCE
COLOR	COLOR	COLOR	COLOR
BIRTHPLACE	BIRTHPLACE	BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION	OCCUPATION	OCCUPATION
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY

CHILD'S NAME OF CHILD
 Primary Registration District No. ...
 Secondary Registration District No. ...
 State ...
 Date of Birth ...
 Sex ...
 Weight ...
 Length ...
 Head ...
 Chest ...
 Arm ...
 Leg ...
 Foot ...
 Middle finger ...
 Little finger ...
 Birthmark ...
 Hair ...
 Eyes ...
 Ears ...
 Mouth ...
 Nose ...
 Skin ...
 Bones ...
 Muscles ...
 Nerves ...
 Blood ...
 Lungs ...
 Liver ...
 Stomach ...
 Intestines ...
 Urinary ...
 Reproductive ...
 Other ...

2
 DEPARTMENT OF PUBLIC HEALTH
 STATE OF IDAHO
 DIVISION OF VITAL STATISTICS

FORM V. S. No. 5-25 M-19

RECEIVED DEC 11 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

55612

File No. 64

Registered No. 64

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of JeffersonCity of CanbyRegistration District No. 98Primary Registration District No. 2176

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Shelton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

8 29 1926
(Month) (Day) (Year)

7. AGE

Shelton
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

Wm

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Raymond Bohney

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Emily Louise Richardson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray Bohney
Canby, Ida

(Address)

15.

Filed 12/10 19 26 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 29 26
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Shelton
About 6 1/2 mo.
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Robert J. Lee M. D.19..... (Address) Robert J. Lee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19.....

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

County of KootenaiCity of Spirit LakeNo. 815123028212 St.Registration District No. 45State File No. 147307

Hospital

Primary Registration District No.

Local Registrar's No. 31

FULL NAME OF CHILD

Clayton Hanni

(Certificate of no value without full name of child)

Sex of Child

M.Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
birthOct 231926

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

None

Number of child of this mother, including present birth

4

Number of child of this mother now living, including present birth

3FULL
NAME

FATHER

John Hanni

RESIDENCE

Spirit Lake Id

COLOR

WhAGE AT LAST
BIRTHDAY40

(Years)

BIRTHPLACE

Montpelier Id

OCCUPATION

MinerFULL
MAIDEN
NAME

MOTHER

Agnes Bassett

RESIDENCE

Spirit Lake Id

COLOR

WhAGE AT LAST
BIRTHDAY31

(Years)

BIRTHPLACE

Mendon Utah

OCCUPATION

House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ^{Born alive} Stillborn at 9:15 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

A. C. Spooner

(Physician or midwife)

Address

Spirit Lake Id

Filed

Oct 24 1926A. C. Spooner

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 27 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

County of AdairCity of Spirit LakeRegistration District No. 45

Primary Registration District No. _____

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clayton Hammi

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE Wh. 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6 DATE OF BIRTH (month, day and year) Oct 23, 19267 AGE Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Spirit Lake Ida
(State or country)10 NAME OF FATHER John Hammi11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)12 MAIDEN NAME OF MOTHER Agnes Bassett13 BIRTHPLACE OF MOTHER (city or town) Menden Utah
(State or country)14 Informant John Hammi
(Address) Spirit Lake Ida15 Filed Oct-23, 1926 Al Spooner
Registrar

DO NOT WRITE IN THIS SPACE

State File No. 55617Local Registrar's No. 17MEDICAL CERTIFICATE OF DEATH 1896

16 DATE OF DEATH

(Month) Unknown (Day) _____ (Year) _____

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn - premature
(about 8 mos.)Placenta praevia
(duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) Al Spooner M. D.Oct 23, 1926 (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Spirit Lake Ida Date of Burial Oct 23 192620. Undertaker none Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED DEC 10 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai

City of Boise

CERTIFICATE OF BIRTH

No. 386206028-38 St. Registration District No. 30 State File No. 147326

Hospital _____ Primary Registration District No. 1057 Local Registrar's No. 1123

FULL NAME OF CHILD No name Thorner

(Certificate of no value without full name of child)

Sex of Child <u>F</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Nov. 6</u> 192 <u>6</u>
(To be answered only in event of plural births)			(Month) (Day) (Year)	

What bactericidal solution was used in eyes? Yes sal

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Ralph Thorner
RESIDENCE 20th St. Chgo
COLOR White AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE N. Dakota
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Phelma Thorner
RESIDENCE 20th St.
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE N. Dakota
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was (Born Alive) Stillborn at 12 A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. H. Brennan

(Physician or midwife)

Address _____

Filed Dec 10 1926 H. H. Brennan

Registrar.

Registrar.

2

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
IDAHO
CERTIFICATE OF BIRTH

County of Blaine
City of Blaine
No. 1000 of 1000 St.
Registration District No. 1000
Primary Registration District No. 1000
Hospital Blaine
Full name of child John
Sex of child Male
Date of birth 10/10/1911
Month 10 Year 1911
Certificate of no value without full name of child

What particular section was used in event?
Number of child of this mother, including present birth
Number of child of this mother, including present birth
Full name John
Residence Blaine
Color White
Age at last birthday 10
Birthplace Idaho
Occupation Student
Residence Blaine
Color White
Age at last birthday 10
Birthplace Idaho
Occupation Student
MOTHER
Full name John
Residence Blaine
Color White
Age at last birthday 10
Birthplace Idaho
Occupation Student

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was born at Blaine on the date above stated.
When there was no attending physician or midwife, then the father, grandmother, or another male relative, A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names and from a supplemental report.
Signature of physician or midwife John
Address Blaine
Filed 10/10/1911

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF BLAINE, IDAHO, THIS 10th DAY OF OCTOBER, 1911.

PLACE OF BIRTH

RECEIVED DEC 6 - 1926

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of MinidokaCity of RupertNo. 231716-034619 St. Registration District No. 19 State File No. 147391Hospital _____ Primary Registration District No. 2015 Local Registrar's No. 150FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Boy</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>Yes</u>	Date of birth <u>11</u> <u>16</u> <u>1926</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? Ag No 3Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Geo M Stalnaker
RESIDENCE Rupert

COLOR White AGE AT LAST BIRTHDAY 22
(Years)

BIRTHPLACE UtahOCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Zelila Ward
RESIDENCE Rupert

COLOR White AGE AT LAST BIRTHDAY 30
(Years)

BIRTHPLACE IdaOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ^{Born alive} at 8:30 p M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

(Physician or midwife)

Address

Filed

Rupert Idaho
Nov 20 1926 E. H. Elmore

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED
 DIVISION OF INVESTIGATION
 U. S. DEPARTMENT OF JUSTICE
 WASHINGTON, D. C.
 MAY 10 1933

RECEIVED
 DIVISION OF INVESTIGATION
 U. S. DEPARTMENT OF JUSTICE
 WASHINGTON, D. C.
 MAY 10 1933

CERTIFICATE OF BIRTH

Registration District No. 61
 Primary Registration District No. 2
 Local Registrar's No. 100

FILE NAME OF CHILD

(Certificate of no value without full name of child)
 Name of child (Last, first, middle)
 Sex Male
 Date of birth (Month, Day, Year)
 Place of birth (City, State, Country)
 (To be answered only in case of dual birth)

And no other name was used in case

NAME	RESIDENCE	COLOR	AGE AT LAST BIRTHDAY (Year)	BIRTHPLACE	OCCUPATION
FATHER					
MOTHER					

Number of child of this mother now living including present birth 1
 Number of child of this mother including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at 100
 (Signature)
 (Physician or Midwife)

*When there was no attending physician or midwife then the father, householder, or neighbor must sign this return. A newborn child is one that neither breathed nor showed other evidence of life after birth.

Give names added from a supplemental report.

Address 100
 Filed 100

RECEIVED DEC 4 - 1926

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTHCounty of My Perce
City of Gifford
No. 893-206 635-253 St.Registration District No. 92File No. S 147432

Hospital _____

Primary Registration District No. 2170Registered No. 5

FULL NAME OF CHILD

Baby HillSex of
ChildMTwin
Triplet
or other?

and

Number
in order
of birthLegiti
mate?yesDate of
Birth11
(Month)6
(Day)1926
(Year)FULL
NAMEElijah Hill

FATHER

RESIDENCE

Gifford

COLOR

WAGE AT LAST
BIRTHDAY34
(Years)

BIRTHPLACE

W. Va.

OCCUPATION

farmerFULL
MAIDEN
NAMEEster Keller

MOTHER

RESIDENCE

Gifford

COLOR

WAGE AT LAST
BIRTHDAY31
(Years)

BIRTHPLACE

Idaho

OCCUPATION

houseNumber of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born, at 11:30 P M.
on the date above stated. (Born alive or stillborn)*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

E. E. Watts

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

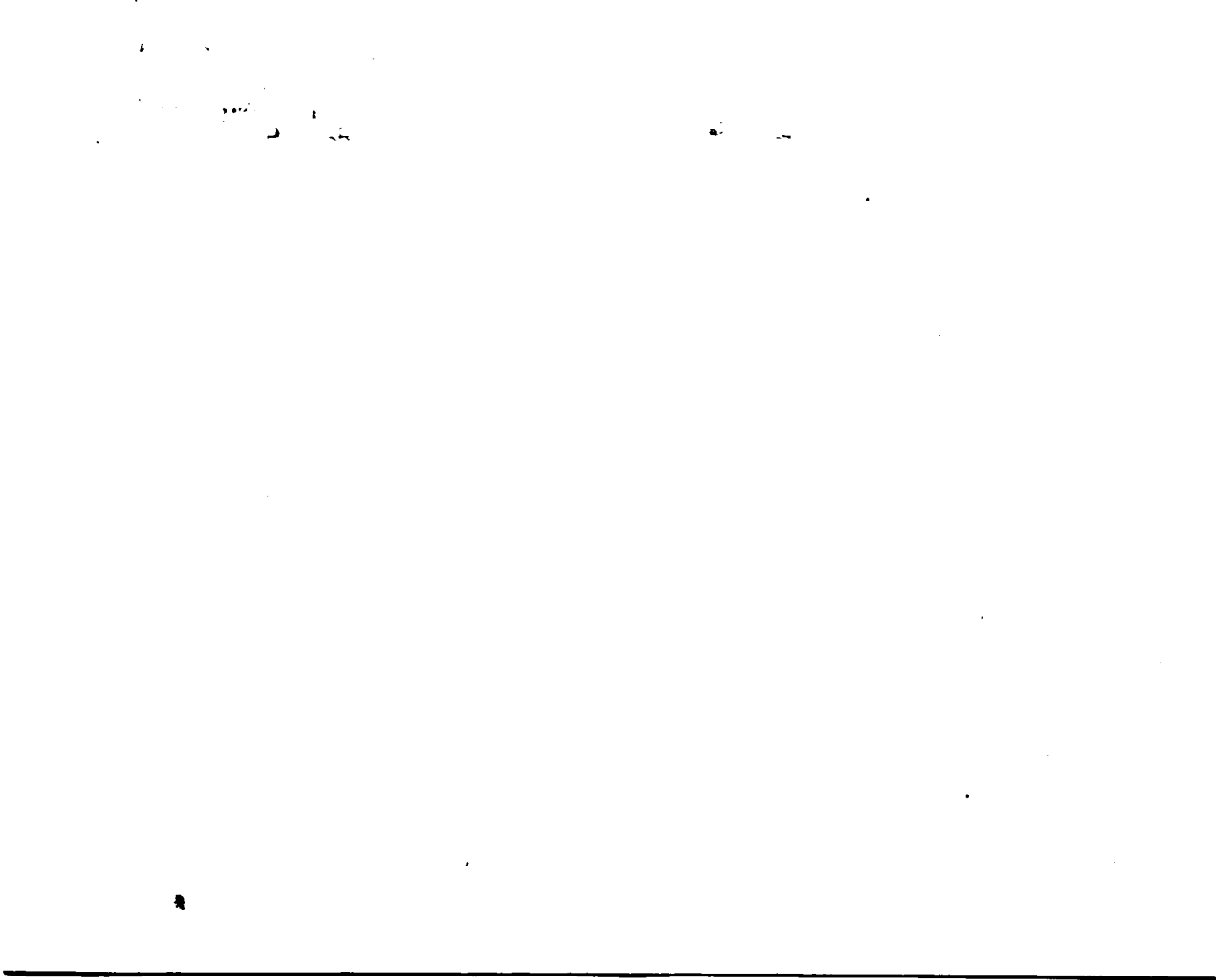
11-7-

1926

E. E. Watts

Registrar

Registrar



FORM V. S. No. 5-25

RECEIVED DEC 1 - 1926

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *My Perce*
City of *Gifford*Registration District No. *92*
Primary Registration District No. *2170*
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Hill*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *55666*
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED *single*
(Write the word.)6. DATE OF BIRTH
11 *6* *1926*
(Month) (Day) (Year)7. AGE
_____ Yrs. _____ Mos. _____ ds.
IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Elijah Hill

11. BIRTHPLACE OF FATHER

(State or Country) *W Va*

12. MAIDEN NAME OF MOTHER

Ester Keller

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Elijah Hill*(Address) *Gifford*15. Filed *11-7* *1926* *E. E. Watts*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov *6* *1926*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____
that I last saw h. *Er* alive on _____ 19____
and that death occurred on the date stated above, at *11 P* M.
The CAUSE OF DEATH* was as follows:
still born
child born before I arrived(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory
(Secondary) _____(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *E. E. Watts* M. D.

_____ 19____ (Address) _____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

McCross Idaho

DATE OF BURIAL

11-8 *1926*

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED DEC 3 - 1926

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Shoshone
City of Kellogg
No 613-127040-596 St. Registration District No. 123 State File No. 147477
Hospital yes Primary Registration District No. 2201 Local Registrar's No. 389
FULL NAME OF CHILD Bone dead.

(Certificate of no value without full name of child)

Sex of Child <u>M</u>	Twin Triplet or other? <u> </u> } and { Number in order of birth <u>2</u>	Legitimate? <u>yes</u>	Date of birth <u>Oct 27</u> 192 <u>6</u> (Month) (Day) (Year)
-----------------------	--	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth <u>1</u>	
FATHER		MOTHER	
FULL NAME <u>Ernest Wesley Hattum</u>		FULL MAIDEN NAME <u>Mary Engle</u>	
RESIDENCE <u>Kellogg</u>		RESIDENCE <u>Kellogg</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Washington</u>		BIRTHPLACE <u>D. C.</u>	
OCCUPATION <u>Lumberman</u>		OCCUPATION <u>House wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 4:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. E. Mason
(Physician or midwife)

Give names added from a supplemental report.
 , 1926
Registrar.

Address
Filed Nov. 30 1926 Mrs. Helen M. Bride
Registrar.

[illegible]

100

(Physician or Nurse)
Address

I hereby certify that I attended the birth of this child, who was born alive at the above place

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

NAME	RESIDENCE	AGE AT LAST BIRTHDAY	SEX	DATE OF BIRTH	PLACE OF BIRTH	OCCUPATION
<u>WILLIAM</u>	<u>1000</u>	<u>10</u>	<u>M</u>	<u>10</u>	<u>10</u>	<u>10</u>

Number of child in this mother's family 10

Number of child of this mother, including preceding 10

NOTED

1. Name of the person or organization: THE UNITED STATES OF AMERICA
 2. Address: WASHINGTON, D.C. 20540
 3. City: WASHINGTON State: D.C. Zip: 20540
 4. Country: UNITED STATES OF AMERICA
 5. Telephone: (202) 456-7890
 6. Fax: (202) 456-7891
 7. E-mail: usa@state.gov
 8. Website: www.state.gov
 9. Other: U.S. Department of State
 10. Signature: [Signature]
 11. Title: Secretary of State
 12. Date: 10/10/2001
 13. Printed Name: John F. Kennedy
 14. Title: President of the United States
 15. Date: 10/10/2001
 16. Printed Name: George W. Bush
 17. Title: President of the United States
 18. Date: 10/10/2001
 19. Printed Name: Al Gore
 20. Title: Vice President of the United States
 21. Date: 10/10/2001
 22. Printed Name: Joe Biden
 23. Title: Vice President of the United States
 24. Date: 10/10/2001
 25. Printed Name: Barack Obama
 26. Title: President of the United States
 27. Date: 10/10/2001
 28. Printed Name: Mitt Romney
 29. Title: President of the United States
 30. Date: 10/10/2001
 31. Printed Name: Paul Ryan
 32. Title: President of the United States
 33. Date: 10/10/2001
 34. Printed Name: Donald Trump
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 175. Printed Name: Barack Obama
 176. Title: President of the United States
 177. Date: 10/10/2001
 178. Printed Name: Mitt Romney
 179. Title: President of the United States
 180. Date: 10/10/2001

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25-11-19

RECEIVED NOV 3 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2201
(No. _____ St.)

State File No. 55327
Local Registrar's No. 109

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Waltman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH
Oct 27 1926
(Month) (Day) (Year)

7. AGE died at birth
IF LESS than 1 day how many
_____ hrs. or _____ min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER Emmett Waltman

11. BIRTHPLACE OF FATHER Washington
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Erfle

13. BIRTHPLACE OF MOTHER N. Dak
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emmett Waltman
(Address) Kellogg Idaho

15. Filed Oct. 27 1926 Mrs. Helen M. Baird
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 27 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____,
that I last saw h. _____ alive on _____ 19____,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Born Dead,

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

1/4 (Signed) J. R. Mason M. D.
27 19 26 (Address) Kellogg, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Kellogg Idaho DATE OF BURIAL Oct 28 19 26

20. UNDERTAKER M. C. Hornum ADDRESS Kellogg, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 22 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

493126 001864-

County of Ada

JAN 3 1927

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 147632

No. St. Registration District No. 2 State File No.

Hospital St. Alphonsus Primary Registration District No. 1004 Local Registrar's No. 510

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child	Male	Twin Triplet or other?		and	Number in order of birth	Legitimate? Yes.	Date of birth	11/26/26	192
						(To be answered only in event of plural births)	(Month)	(Day)	(Year)

What bactericidal solution was used in eyes? Ag. NO. #3.

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth

FATHER
FULL NAME
Spencer Laurel MillerRESIDENCE
Twin Falls, Idaho.COLOR
white
AGE AT LAST BIRTHDAY 23
(Years)BIRTHPLACE
North Carolina

OCCUPATION

salesman.

MOTHER
FULL MAIDEN NAME
Ruth Dorothy Hodden,RESIDENCE
Twin Falls, Idaho.COLOR
white
AGE AT LAST BIRTHDAY 18
(Years)BIRTHPLACE
Uah.

OCCUPATION

Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was { Born alive } at 7:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address Boise Idaho

Filed 12-6 1926

Registrar.

Registrar.

STATE OF TEXAS
 DEPARTMENT OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

JAN 28 1902

Registration District No. 10
 Hospital St. Anthony's Primary Registration District No. 100
 FULL NAME OF CHILD
 (Certificate of no value without full name of child)
 Date of Birth Year Month Day
 Sex Male
 (The sex answered only in case of female child)

What hospital or institution was used in event of birth
 Number of child of this mother now living, including present birth
 FATHER
 FULL NAME
 CHILD'S NAME
 CHILD'S BIRTHDAY
 AGE AT LAST BIRTHDAY
 COLOR
 BIRTHPLACE
 NORTH CAROLINA
 OCCUPATION
 CHILD'S BIRTHDAY
 AGE AT LAST BIRTHDAY
 COLOR
 BIRTHPLACE
 NORTH CAROLINA
 OCCUPATION
 CHILD'S BIRTHDAY
 AGE AT LAST BIRTHDAY
 COLOR
 BIRTHPLACE
 NORTH CAROLINA
 OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was born at
 Date of Birth
 Signature of Physician or Midwife
 Address
 City
 State
 County

RECEIVED JAN 28 1902
 DEPARTMENT OF VITAL STATISTICS
 STATE OF TEXAS

WRITE PLAINLY, WITH UNFADING INK. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED
DEC 2 1926
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 55400

PLACE OF DEATH

County of Ada BUREAU OF VITAL STATISTICS District No. 2

City of Boise Registration District No. 1004

Local Registrar's No. 289

(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Miller

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) November 26/26

7 AGE Years Months Days 1 If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boise, Ida
(State or country)

10 NAME OF FATHER Spencer Miller

11 BIRTHPLACE OF FATHER (city or town) Ash Co. N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Hoder

13 BIRTHPLACE OF MOTHER (city or town) Salt Lake City, Utah
(State or country)

14 Informant Spencer Miller
(Address) Twin Falls, Idaho

15 Filed 11-30, 1926 R. H. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 26 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

to 19 to 19

that I last saw him alive on 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Strangulation,
2 cord, due to arm presentation
at birth

(duration) yrs. mos. da.

CONTRIBUTORY Arm presentation
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted
if not at place of death? K

Did an operation precede death? K Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. P. Springer, M. D.

11/29, 1926, (Address) Boise, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Morris Hill Cemetery 11/29 1926

20 Undertaker

Schneider & Davis Address Boise

to Spinning

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

235720 09.866
PLACE OF BIRTH

RECEIVED JAN 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

City of Selle

No. St. Registration File No. 147764

Hospital Page Primary Registration District No. 2155 Local Registrar's No. 147764

FULL NAME OF CHILD George Sletager
(Certificate of no value without full name of child)

Sex of Child Male	Twin Triplet or other? } and { Number in order of birth	Legitimate? Yes	Date of birth Dec 20, 1926
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Helmer Sletager
RESIDENCE Selle
COLOR White AGE AT LAST BIRTHDAY 20
(Years)
BIRTHPLACE Gerry Minn
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Rosella Howe
RESIDENCE Selle
COLOR White AGE AT LAST BIRTHDAY 23
(Years)
BIRTHPLACE Tomhawk Wis.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~born~~ ^{born} at 2.35 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. B. Evans
Physician
(Physician or midwife)

Address Over, Idaho

Filed Jan. 3 1927
Deputy Registrar



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WRITE PLAINLY, WITH UNFADING INK—TAKING AS MUCH SPACE AS POSSIBLE. AGE should be stated EXACTLY, PHYSICIANS N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **55213**

PLACE OF DEATH

County of Benewah
City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. _____

(No. _____)
(If death occurred in hospital or institution, give its name instead of street and number.)

2. FULL NAME

Infant Stetager

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Dec. 20, 1926

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

Stillborn

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Sandpoint Idaho.

10 NAME OF FATHER

Helmer Stetager

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Dary,

12 MAIDEN NAME OF MOTHER

Rosella Howe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Tonahawke

14

Informant

Helmer Stetager

(Address)

Sandpoint, Ida. R.F.D. #7,

15

Filed

12-22, 1926

Floyd G. Wendle

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Stillborn

(Month)

(Day)

19

(Year)

December 20, 1926

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on _____, 19____, to _____, 19____.

and that death occurred, on the date stated above, at 2:10 p. m.

The CAUSE OF DEATH* was as follows:

Mother had a Placental
Ravina

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed)

W. B. Evans M. D.

Dec. 22, 1926

(Address)

Idaho, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Lakeview Cemetery

Dec. 23, 1926

20 Undertaker

Address

L. G. Moon

Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

415-122-009-553
PLACE OF BIRTH

RECEIVED JAN 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

City of Sandpoint Idaho

CERTIFICATE OF BIRTH **147772**

No. _____ St. _____ Registration District No. 76 State File No. _____

Hospital Page Primary Registration District No. 2155 Local Registrar's No. _____

FULL NAME OF CHILD Robert Wilding Davies
(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 22, 1926</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Wilding Davies
RESIDENCE Sandpoint Idaho
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Seattle Wash
OCCUPATION Lumber man

MOTHER
FULL MAIDEN NAME Maude B Nelson
RESIDENCE Sandpoint Idaho
COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Minneapolis Minn
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1.30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature) Floyd G Wendle
M. H.
(Physician or midwife)

Address Sandpoint Idaho

Filed Jan. 3 1927 Viola Allen
Deputy Registrar.

Registrar.

1091 MB

WRITE PLAINLY, WITH UNFADING INK—FILL IN ALL SPACES AND ATTACH TO BACK OF CERTIFICATE. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

55212

State File No.....

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No.....

(No. _____)
If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Infant Davies Stillborn

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

1 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

16 DATE OF DEATH Dec. 22, 1926
(Month) (Day) (Year)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
That I last saw him alive on _____, 19____,
and that death occurred, on the date stated above, at _____ m.

6 DATE OF BIRTH (month, day and year) Dec. 28, 1926

7 AGE Stillborn Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. _____ min.

The CAUSE OF DEATH* was as follows:
Primature Birth
5 Mo Gestation
CAUSE UNKNOWN
(duration) _____ yrs. _____ mos. _____ ds.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY CAUSE UNKNOWN
(Secondary) (duration) _____ yrs. _____ mos. _____ ds.

9 BIRTHPLACE (city or town) Sandpoint Idaho
(State or country)

18 Where was disease contracted
If not at place of death? _____

10 NAME OF FATHER W. E. Davies

Did an operation precede death? _____ Date of _____

11 BIRTHPLACE OF FATHER (city or town) Seattle Wash
(State or country)

Was there an autopsy? _____

12 MAIDEN NAME OF MOTHER Maudie E. Nelson

What test confirmed diagnosis?
(Signed) Floyd G. Wedgale M. D.
12-22-26 (Address) Sandpoint Idaho

13 BIRTHPLACE OF MOTHER (city or town) Minneapolis Minn
(State or country)

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

14 Informant W. E. Davies
(Address) Sandpoint Idaho

19 Place of Burial, Cremation, or Removal Laprevoir Cemetery Date of Burial Dec. 23, 1926

15 Filed 12-22-26 Floyd G. Wedgale
Registrar

20 Undertaker L. H. Moon Address Sandpoint, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonneville RECEIVED JAN 6 1927

City of

CERTIFICATE OF BIRTH 147791

No. 49126010769 St. Registration District No. 73 State File No.

Hospital Primary Registration District No. 1ND Local Registrar's No. 152

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Dec 26</u> 192 <u>6</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth

FATHER
FULL NAME Hugh Caldwell Martin
RESIDENCE Swan Valley Idaho
COLOR white AGE AT LAST BIRTHDAY 49 (Years)
BIRTHPLACE Evansville Wyoming
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ila Bell Poircatt
RESIDENCE Swan Valley Idaho
COLOR white AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Edgewood Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 8:30 a. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report., 192

(Signature) H. Spencer, M.D.

(Physician or midwife)

Address Idaho Falls Idaho

Filed 12/31 1926 W. J. Funnell

Registrar.

Registrar.

CERTIFICATE OF BIRTH

Registration District No. 35
Primarily Registration District No. 113

Certification of no value without full name of child

Full Name of Child: John William Smith
Date of Birth: Jan 15 1900
Place of Birth: St. Louis, Mo.
Sex: Male
Color: White
Religion: Methodist
Occupation: Student

What medical condition was noted in case?

Number of child of this mother born living: 1
Name of child: John William Smith
Residence: St. Louis, Mo.
Color: White
Birthplace: St. Louis, Mo.
Occupation: Student

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of the child named above on the date above stated.

Signature of Physician or Midwife: [Signature]
Address: St. Louis, Mo.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-15-2000 BY 60322 UCBAW/STP

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH 698 720 510 -866
County of Bonneville
City of Idaho Falls
No. _____ St. Registration District No. 23 State File No. 147822
Hospital L. I. O. S. Primary Registration District No. 2120 Local Registrar's No. 1418221
FULL NAME OF CHILD Stell Birth Fry
(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>1</u>	and { Number in order of birth <u>1</u> }	Legitimate? <u>yes</u>	Date of birth <u>12-20</u> <u>1926</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth <u>0</u>	
FATHER FULL NAME <u>Ralph L. Fry</u> RESIDENCE <u>Idaho Falls</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>28</u> (Years) BIRTHPLACE <u>Kansas</u> OCCUPATION <u>Salesman</u>		MOTHER FULL MAIDEN NAME <u>Mauden Horne</u> RESIDENCE <u>Idaho Falls</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>29</u> (Years) BIRTHPLACE <u>Rigby Idaho</u> OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7¹⁵ p. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Harry R. Williams
M. D.

(Physician or midwife)

Address Idaho Falls Idaho

Filed Dec 22 1926 W. J. Williams

Registrar.

Registrar.

THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF VITALS, CITY AND COUNTY OF NEW YORK, FOR THE YEAR 1914.

I hereby certify that I received the birth of this child, who was
 (Signature)
 Registrar of Births

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

FATHER		MOTHER	
NAME		NAME	
RESIDENCE		RESIDENCE	
COLOR		COLOR	
BIRTHPLACE		BIRTHPLACE	
OCCUPATION		OCCUPATION	
AGE AT LAST BIRTHDAY		AGE AT LAST BIRTHDAY	

CHILD		MOTHER	
NAME		NAME	
RESIDENCE		RESIDENCE	
COLOR		COLOR	
BIRTHPLACE		BIRTHPLACE	
OCCUPATION		OCCUPATION	
AGE AT LAST BIRTHDAY		AGE AT LAST BIRTHDAY	

NAME OF CHILD

DATE OF BIRTH

PLACE OF BIRTH

NAME OF PHYSICIAN OR MIDWIFE

SIGNATURE

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PRELIMINARY STATEMENT. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 6 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 55833

County of Bonneville, Registration District No. 73
City of Idaho Falls, Primary Registration District No. 214-0

Local Registrar's No. 194

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Fry

(a) Residence. No. 225-6 St.

(Usual place of abode)
Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, none hrs. or none min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Idaho Falls
(State or country) Idaho

10 NAME OF FATHER P. L. Fry

11 BIRTHPLACE OF FATHER (city or town) Kansas
(State or country)

12 MAIDEN NAME OF MOTHER Manda Howe

13 BIRTHPLACE OF MOTHER (city or town) Prigby Idaho
(State or country)

14 Informant P. L. Fry
(Address) 225-6

15 Filed Dec 21, 1926 C. J. Finn
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 20 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1926, to Dec 20, 1926

that I last saw him on Stillborn 1926

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn - husband. Dead
several days (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry L. Williams M. D.
12/21, 1926 (Address) Idaho Falls, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Pocatello Idaho Dec 21 1926

20. Undertaker Address

V. F. McMan Idaho Falls
Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

FILE # 148003

YEAR 1926

IDAHO STILLBIRTH CERTIFICATE

**☒ VOID DUP OF STILLBIRTH
1926-146294**

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED DEC 30 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

148109

County of Jefferson

City of Bigl

No. 573-202026-91

Registration District No. 98

State File No.

Hospital

Primary Registration District No. 2176

Local Registrar's No. 243

FULL NAME OF CHILD

Jean Ellsworth

(Certificate of no value without full name of child)

Sex of Child

Female

Twin
Triplet
or other?

and {

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

Dec. 2

1926

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Argyrol

Number of child of this mother, including present birth

3

Number of child of this mother now living, including present birth

3

FULL
NAME

FATHER

Edmund Frank Ellsworth

RESIDENCE

Bigl, Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

32

(Years)

BIRTHPLACE

Lewistown, Idaho

OCCUPATION

Jeweler

FULL
MAIDEN
NAME

MOTHER

Ana Myers Josephine Bray

RESIDENCE

Bigl, Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

26

(Years)

BIRTHPLACE

Columbia, Missouri

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Born alive
Stillborn

at

2 33

M.

on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. A. Anderson, M.D.

(Physician or midwife)

Address

Bigl, Idaho

Filed

Dec 10 1926

W. H. Hale, M.D.

Registrar.

Registrar.

604

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

819-230029-256
PLACE OF BIRTH

RECEIVED JAN 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah

City of Troy Ida

CERTIFICATE OF BIRTH 148126

No. _____ St. _____ Registration District No. 64 State File No. _____

Hospital _____ Primary Registration District No. 2144 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>12-30-1926</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER	MOTHER
FULL NAME <u>Roland Harris</u>	FULL MAIDEN NAME <u>Anna Snoren</u>
RESIDENCE <u>Troy Idaho</u>	RESIDENCE <u>Troy Idaho</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>27</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>S. Dakota</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2 4 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

December 31, 1926
Lucy M. Pickard
Registrar.

(Signature)

Chas. A. Meyer
Physician
(Physician or midwife)

Address

Troy, Idaho
Filed Dec 31, 1926
Lucy M. Pickard
Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 5 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

55924

State File No.....

PLACE OF DEATH

County of LatahCity of Troy

Registration District No.....

Primary Registration District No.....

Local Registrar's No.....

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

12-30-26

7 AGE

Years

Months

Days

If LESS than

hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Name of employer

9 BIRTHPLACE (city or town) (State or country)

Troy Idaho

10 NAME OF FATHER

Roland Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Troy, Idaho -

12 MAIDEN NAME OF MOTHER

Anna Snaen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Berkeley S. Dakota

14

Informant

(Address)

Troy, Idaho -

15

Filed

Dec 31 1926 Lucy M Pickard

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 30
(Month) (Day)1926
(Year)17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1926, to Dec 30, 1926.that I last saw him alive on, 1926.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. A. Meyer, M. D.Dec 30, 1926. (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Burnt Ridge cemDec 30 1926

20. Undertaker

Address

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

JAN 6

STATE OF IDAHO
DEPARTMENT OF PUBLIC
HEALTH
BUREAU OF VITAL STATISTICS

S

County of Fremont

City of Parker

No. 955-118022-845 St.

Registration District No. 100

State No. 148174

Hospital

Primary Registration District No. 2178

Local Registrar's No. 1211

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

Male

Twin
Triplet
or other?

} and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

Dec 18

1926

(Month) (Day) (Year)

What bactericidal solution was used in eyes? 70% boric acid solution

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

Burdett Remington

RESIDENCE

Parker Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

17
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Martha Hanks

RESIDENCE

Parker Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

17
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 5/30 a.m.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. B. King

(Physician or midwife)

Address

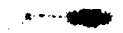
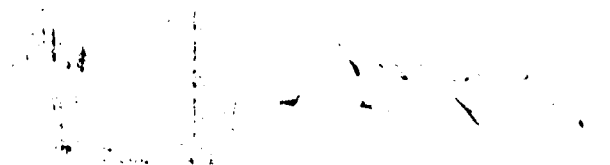
Filed

1/3

1927

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 RECEIVED JUN 13 1927 CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 99
County of Freemant Primary Registration District No. 2177
City of Parker (No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 57612
Registered No. 197

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stieborn

If death occurred in hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Dec 18 1926
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER B. J. Remington

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Martha Hanks

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Remington
(Address) Parker Idaho

15. Filed June 6th 1927 COM Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 18 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____, that I last saw h_____ alive on _____ 191____, and that death occurred on the date stated above, at _____ M. The CAUSE OF DEATH* was as follows:
Stieborn
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) unknown
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. B. Smith M. D.
June 16 1927 (Address) Parker Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Parker Dec 18 1927
20. UNDERTAKER None ADDRESS _____

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

913106 035 944

PLACE OF BIRTH

RECEIVED DEC 16 1926

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-2-17

CERTIFICATE OF BIRTH

S148199

County of *Boise*City of *Caldwell*Registration District No. *128*

File No.

No. St.

Primary Registration District No. *Caldwell & Vicinity*

Registered No.

Hospital

FULL NAME OF CHILD

Stillborn Jimmy Rakston

Sex of Child

*Male*Twin
Triplet
or other?and { Number
in order
of birth

Legitimate?

yes

Date of Birth

11 6 1926
(Month) (Day) (Year)

FULL NAME

*FATHER
Chas Wallace Rakston*

FULL MAIDEN NAME

MOTHER

Marie Russell

RESIDENCE

Caldwell Idaho

RESIDENCE

Caldwell Idaho

COLOR

white

AGE AT LAST BIRTHDAY

20
(Years)

COLOR

white

AGE AT LAST BIRTHDAY

21
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

farmer

OCCUPATION

*Housewife*Number of child of this mother, including present birth... *2*... Number of children of this mother now living, including present birth... *1*...

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was... *Stillborn*... at *7:30 A.M.*
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

George Gaignard
Physician

(Physician or midwife)

Given names added from a supplemental report.

Address

Caldwell Idaho

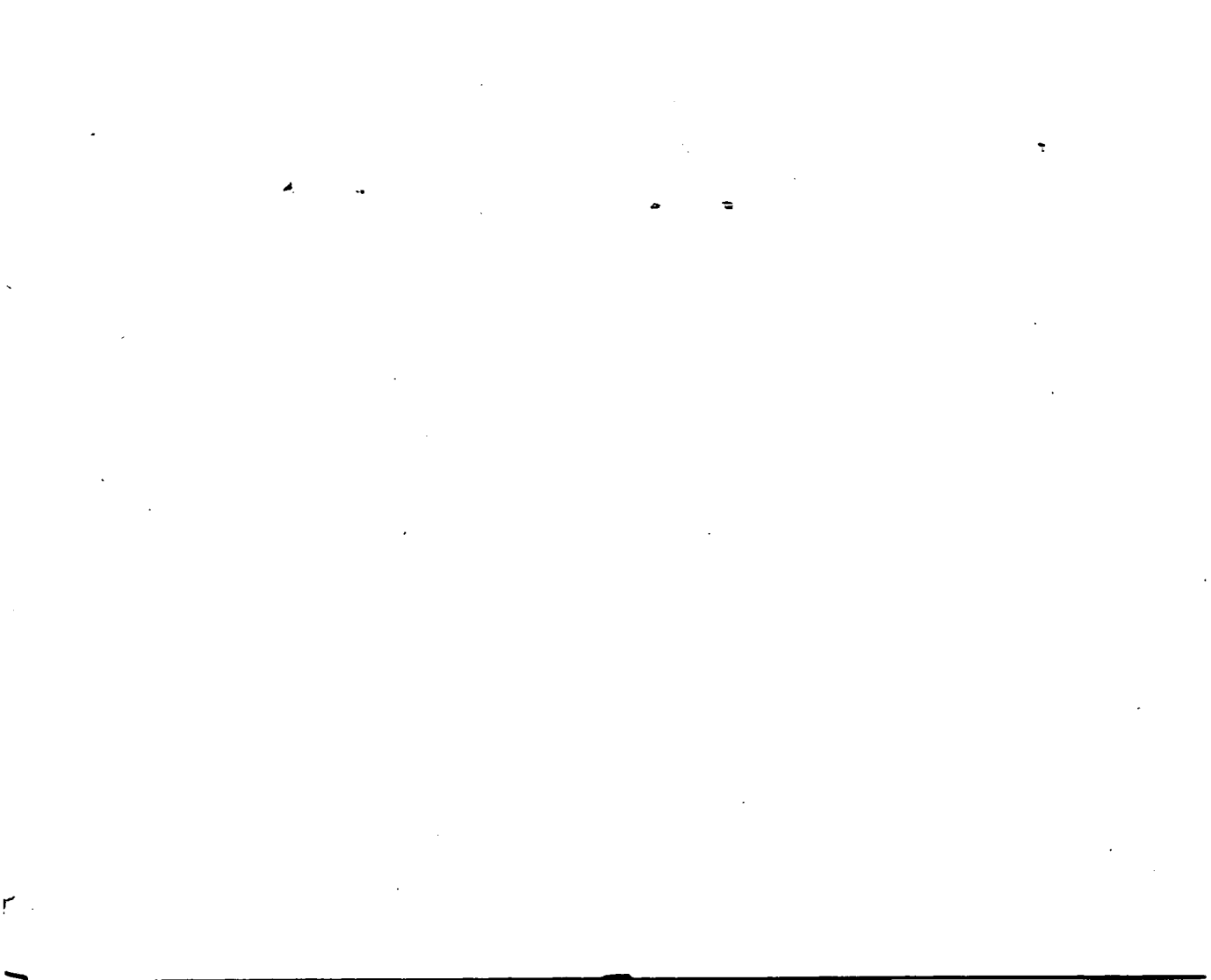
Filed

Nov 26 1926

Registrar

Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. RECEIVED DEC 16 1926

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nevada
City of CaldwellRegistration District No. 128Primary Registration District No. 1(No. Caldwell & Blaine)State File No. 55958

Local Registrar's No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stellbarn Jimmy Ralston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

White

(Write the word)

6. DATE OF BIRTH

11 6 1926
(Month) (Day) (Year)

7. AGE

Yrs. — Mos. — ds. —

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Chuck Wallace Ralston

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Marie Russell

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marie Russell Ralston
(Address) Caldwell Idaho

15.

Filed Nov. 1926 George Gaignard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 6 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19,that I last saw h..... alive on 19,and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Stellbarn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaignard M. D.11 1926 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Caldwell Idaho

DATE OF BURIAL

11-7- 1926

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, "Foreman, "Manager, "Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers, who receive a definite salary,** may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**"); **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia,**" unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, "Anaemia**" (merely symptomatic), "**Atrophy, "Collapse, "Coma, "Convulsions, "Debility, "Congenital, "Senile,**" etc.), "**Dropsy, "Exhaustion, "Heart Failure, "Hemorrhage, "Inanition, "Marasmus, "Old age, "Shock, "Uraemia, "Weakness,**" etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

253 220042-265
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls RECEIVED JAN 11 1927
City of Twin Falls
No. _____ St. Registration District No. 37 State File No. _____
Hospital T. I. Cox Gen Primary Registration District No. 1085 Local Registrar's No. _____

CERTIFICATE OF BIRTH 148300

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>female</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Dec 20</u> 192 <u>6</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FATHER		MOTHER	
FULL NAME	<u>Charles H. Secord</u>	FULL MAIDEN NAME	<u>Effie Myrtle Sova</u>
RESIDENCE	<u>198. Washington St.</u>	RESIDENCE	<u>198. Washington St.</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>59</u> (Years)	AGE AT LAST BIRTHDAY	<u>39</u> (Years)
BIRTHPLACE	<u>Canada</u>	BIRTHPLACE	<u>Winchester, Kansas</u>
OCCUPATION	<u>Carpenter</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 5:50 P. M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 1926

(Signature) E. D. Weaver

(Physician or midwife)

Address 27

Filed 1-10 1926

Registrar.

Registrar.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE BIRTH RECORD ACT, 1909, AND THE BIRTH RECORD ACT, 1911, AND THE BIRTH RECORD ACT, 1913, AND THE BIRTH RECORD ACT, 1915, AND THE BIRTH RECORD ACT, 1917, AND THE BIRTH RECORD ACT, 1919, AND THE BIRTH RECORD ACT, 1921, AND THE BIRTH RECORD ACT, 1923, AND THE BIRTH RECORD ACT, 1925, AND THE BIRTH RECORD ACT, 1927, AND THE BIRTH RECORD ACT, 1929, AND THE BIRTH RECORD ACT, 1931, AND THE BIRTH RECORD ACT, 1933, AND THE BIRTH RECORD ACT, 1935, AND THE BIRTH RECORD ACT, 1937, AND THE BIRTH RECORD ACT, 1939, AND THE BIRTH RECORD ACT, 1941, AND THE BIRTH RECORD ACT, 1943, AND THE BIRTH RECORD ACT, 1945, AND THE BIRTH RECORD ACT, 1947, AND THE BIRTH RECORD ACT, 1949, AND THE BIRTH RECORD ACT, 1951, AND THE BIRTH RECORD ACT, 1953, AND THE BIRTH RECORD ACT, 1955, AND THE BIRTH RECORD ACT, 1957, AND THE BIRTH RECORD ACT, 1959, AND THE BIRTH RECORD ACT, 1961, AND THE BIRTH RECORD ACT, 1963, AND THE BIRTH RECORD ACT, 1965, AND THE BIRTH RECORD ACT, 1967, AND THE BIRTH RECORD ACT, 1969, AND THE BIRTH RECORD ACT, 1971, AND THE BIRTH RECORD ACT, 1973, AND THE BIRTH RECORD ACT, 1975, AND THE BIRTH RECORD ACT, 1977, AND THE BIRTH RECORD ACT, 1979, AND THE BIRTH RECORD ACT, 1981, AND THE BIRTH RECORD ACT, 1983, AND THE BIRTH RECORD ACT, 1985, AND THE BIRTH RECORD ACT, 1987, AND THE BIRTH RECORD ACT, 1989, AND THE BIRTH RECORD ACT, 1991, AND THE BIRTH RECORD ACT, 1993, AND THE BIRTH RECORD ACT, 1995, AND THE BIRTH RECORD ACT, 1997, AND THE BIRTH RECORD ACT, 1999.

PLACE OF BIRTH

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH
County of _____
City of _____
No. _____
Date of Birth _____
Sex _____
Color _____
Weight _____
Length _____
Head _____
Chest _____
Arm _____
Leg _____
Foot _____
Finger _____
Middle _____
Ring _____
Pinky _____
Thumb _____
Nails _____
Hair _____
Eyes _____
Ears _____
Mouth _____
Nose _____
Skin _____
Tattoos _____
Scars _____
Birthmarks _____
Other _____

NAME OF CHILD
First _____
Middle _____
Last _____
Date of Birth _____
Place of Birth _____
Sex _____
Color _____
Weight _____
Length _____
Head _____
Chest _____
Arm _____
Leg _____
Foot _____
Finger _____
Middle _____
Ring _____
Pinky _____
Thumb _____
Nails _____
Hair _____
Eyes _____
Ears _____
Mouth _____
Nose _____
Skin _____
Tattoos _____
Scars _____
Birthmarks _____
Other _____

NAME OF FATHER
First _____
Middle _____
Last _____
Date of Birth _____
Place of Birth _____
Sex _____
Color _____
Weight _____
Length _____
Head _____
Chest _____
Arm _____
Leg _____
Foot _____
Finger _____
Middle _____
Ring _____
Pinky _____
Thumb _____
Nails _____
Hair _____
Eyes _____
Ears _____
Mouth _____
Nose _____
Skin _____
Tattoos _____
Scars _____
Birthmarks _____
Other _____

NAME OF MOTHER
First _____
Middle _____
Last _____
Date of Birth _____
Place of Birth _____
Sex _____
Color _____
Weight _____
Length _____
Head _____
Chest _____
Arm _____
Leg _____
Foot _____
Finger _____
Middle _____
Ring _____
Pinky _____
Thumb _____
Nails _____
Hair _____
Eyes _____
Ears _____
Mouth _____
Nose _____
Skin _____
Tattoos _____
Scars _____
Birthmarks _____
Other _____

BIRTHPLACE
Color _____
Age at Last Birthday _____
Occupation _____
Birthplace _____
Color _____
Age at Last Birthday _____
Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of the child who was _____
on the date above stated.
When there was no attend on the physician
or midwife, then the father, householder
or other person who attended the birth
should make this statement. A signature
is not required if the child is born at home
and is not attended by a physician or midwife.
(Give names added from a supplementary report.)

Signature of Physician or Midwife _____
Address _____
Date _____
Registrar _____
Date _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED JAN 1 1927
PLACE OF DEATH
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 55490

County Twin Falls Registration District No. 37
City of Twin Falls Primary Registration District No. 1885
(No. 198 Wash. St. No. C. D. 1926)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Second
(a) Residence No. 198 Wash. St. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 20 1926

7 AGE Years Months Days If LESS than 1 day, hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Twin Falls (State or country)

10 NAME OF FATHER C. W. Second

11 BIRTHPLACE OF FATHER (city or town) Canada (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) France (State or country)

14 Informant C. W. Second (Address) 198 Wash. St. North Twin Falls

15 Filed 1-10 1926 John J. Goughlin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 20 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ON 12/20, 1926, to 1926, that I last saw him alive on 1926, and that death occurred, on the date stated above, at 6:00 m.

The CAUSE OF DEATH* was as follows:

Still born asphyxia.

CONTRIBUTORY (Secondary)

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. D. Weaver, M. D.

12/23, 1926 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Twin Falls Dec 22 1926

20 Undertaker Address

S. J. Grossman Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

391-128107-659

PLACE OF BIRTH

RECEIVED JAN 18 1927
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine

City of Hailey

No. _____ St. _____

Registration District No. 59

File No. 148455

Hospital _____

Primary Registration District No. 2022

Registered No. 59

FULL NAME OF CHILD

Baby Crane Stillborn

(Certificate of no value without full name of child.)

Sex of
Child

male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

12 28

192

6

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth ✓

Number of child of this mother now living, including present birth ✓

FULL
NAME

FATHER

Don H. Crane

FULL
MAIDEN
NAME

MOTHER

Ebra White

RESIDENCE

Picabo, Ida

RESIDENCE

Picabo, Ida

COLOR

White

AGE AT LAST

BIRTHDAY

(Years)

COLOR

White

AGE AT LAST

BIRTHDAY

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ M.
on the date above stated.

(born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

no doctor (unknown)

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

1-10 1927 Robert H. Wright

Registrar.

Registrar.



1

2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 18 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

56133

State File No.

County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No.)

Local Registrar's No. 43

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) X

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Stillborn Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. L
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Gannett Idaho
(State or country)

10 NAME OF FATHER Don H Crane

11 BIRTHPLACE OF FATHER (city or town) Utah
(State or country)

12 MAIDEN NAME OF MOTHER Elna White

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant H. E. White
(Address) Picabo

15 Filled 1-10 19 27 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 28 19 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

..... 19..... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Picabo Idaho Date of Burial Dec 30 1926

20 Undertaker Gacher & Amos Address Hailey

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

365-119,003-735
PLACE OF BIRTH

RECEIVED JAN 18 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock
City of Pocatello
No. 314 So. 10th St. Registration District No. 28 State File No. 148553
Hospital ✓ Primary Registration District No. 2161 Local Registrar's No. 7945
FULL NAME OF CHILD Baby Lavin
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? ✓ and { Number in order of birth 1 } Legitimate? yes Date of birth 12 - 19 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Stillborn

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
<u>Robert Scott Lavin</u>		<u>Hazel Vera Glim</u>	
<u>Pocatello Idaho</u>		<u>same</u>	
COLOR <u>wh</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)	COLOR <u>wh</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1230 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature) D C Ray

(Physician or midwife)
Address Pocatello, Idaho

Filed 1-1 1927

Registrar.

Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 18 1927
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **56093**

County of Bannock
City of Locatello

Registration District No. 28
Primary Registration District No. 2461
(No. 1119 East Bonnaville)

Local Registrar's No. 4957

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Lavin

(a) Residence. No. 1119 East Bonnaville St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Stillb 17/19/1926

7 AGE Years Months Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Locatello, Ida
(State or country)

10 NAME OF FATHER Robert Lavin

11 BIRTHPLACE OF FATHER (city or town) Orderville, Utah
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Gleim

13 BIRTHPLACE OF MOTHER (city or town) Hopewell, Iowa
(State or country)

14 Informant Robert Lavin
(Address) 1119 East Bonnaville

15 Filed 12/22/26 H. L. Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 19, 1926
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1926 to Dec 19, 1926
that I last saw him alive on 19
and that death occurred, on the date stated above, at 19 m.

The CAUSE OF DEATH was as follows:

Still birth
Breach too large baby

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. C. Ray M. D.
12-20-26 (Address) Locatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Mountain View Date of Burial 12-20-26

20. Undertaker Bannock & Hall Address Locatello, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

294-22-1022-546
PLACE OF BIRTH

RECEIVED FEB 14 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine
City of St Anthony

CERTIFICATE OF BIRTH 148739

No. St. Registration District No. 99 State File No.
Hospital Primary Registration District No. 2177 Local Registrar's No. 611

FULL NAME OF CHILD
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>1</u> } and { Number in order of birth <u>3</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec. 24, 1926</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? Still Born

Number of child of this mother, including present birth. 3 Number of child of this mother now living, including present birth 3

FATHER	MOTHER
FULL NAME <u>Thomas Simpson</u>	FULL MAIDEN NAME <u>Vera Edwards</u>
RESIDENCE <u>St Anthony, Ida</u>	RESIDENCE <u>St Anthony</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>46</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Eggin, Idaho</u>	BIRTHPLACE <u>Willard, Utah</u>
OCCUPATION <u>Penit Laborer</u>	OCCUPATION <u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

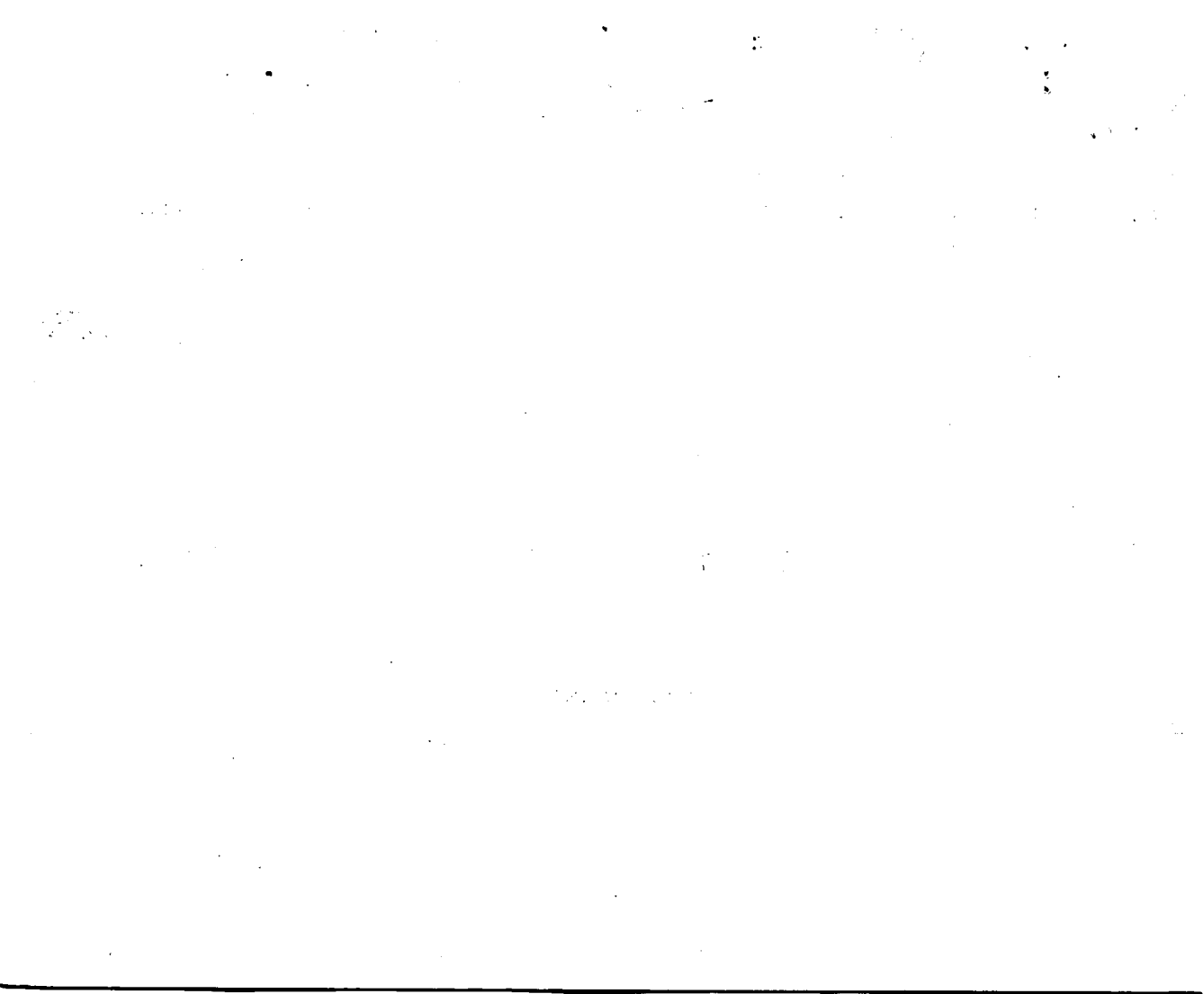
I hereby certify that I attended the birth of this child, who was { Born Alive } at 1145 P. M.
on the date above stated. { Stillborn }

(Signature) P. M. Kelly, M.D.
(Physician or midwife)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 192.....

Address St Anthony, Idaho.
Filed 7/9 1927 W. H. Baum
Registrar. Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

759-289-1028-655
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai RECEIVED JAN 12 1927
City of C. D. Alene CERTIFICATE OF BIRTH 148816
No. 817 Wallace St. Registration District No. 30 State File No. _____
Hospital Boon O'Alene Primary Registration District No. 1051 Local Registrar's No. 1144

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	<u>Birth</u> <u>Triplet</u> or other?	and { Number in order of birth <u>7th</u>	Legitimate? <u>yes</u>	Date of birth <u>Dec 9</u> 192 <u>6</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? Child still born.

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FATHER
FULL NAME Tom R. Yerdes
RESIDENCE 817 Wallace C. D. Alene Ida
COLOR white AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Minonk Illinois
OCCUPATION Real Estate & Insurance

MOTHER
FULL MAIDEN NAME Helis C. Wendland
RESIDENCE 817 Wallace C. D. Alene Ida
COLOR White AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE Marion Illinois
OCCUPATION House-wife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born-alive } at 2 25 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) John O'Leary

(Physician or midwife)

Address Boon O'Alene, Ida

Filed Jan 10 1927

Registrar.

Registrar.

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بدره كماله
شاه

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 12 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

56298

State File No.

PLACE OF DEATH

County of Idaho
City of Coeur d'Alene

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

(No. Coeur d'Alene Idaho)

Local Registrar's No. 1093

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Gerdes

(a) Residence. No. 817 Wallace St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) Dec 9 - 1926

7 AGE Years Months Days 1 If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Idaho

10 NAME OF FATHER J. R. Gerdes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho

12 MAIDEN NAME OF MOTHER Stelen E. Handland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant J. R. Gerdes
(Address) Coeur d'Alene

15 Filled Jan 10, 19 27 D. D. Drennon
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 9 19 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 19 26, to Dec. 9, 19 26, that I last saw him alive on —, 19 —, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Still born.

CONTRIBUTORY (Secondary) Precipitate detachment of placenta, 12 hours.
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John M. Wood, M. D.

Dec 10, 19 26 (Address) Coeur d'Alene Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal St. Thomas Cem Date of Burial 12/10 19 26

20. Undertaker R. S. Mooney Address Coeur d'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

44-115-028-469
PLACE OF BIRTH

RECEIVED JAN 12 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai
City of Rose Lake

CERTIFICATE OF BIRTH **148817**

No. St. Registration District No. 30 State File No.
Hospital Primary Registration District No. 1051 Local Registrar's No. 1145

FULL NAME OF CHILD James Deemling
(Certificate of no value without full name of child)

Sex of Child <u>M</u>	Twin Triplet or other?	and {	Number in order of birth	Legiti- mate? <u>Y</u>	Date of birth <u>Dec 15</u> 192 <u>6</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth <u>6</u>	Number of child of this mother now living, including present birth <u>5</u>
--	---

FULL NAME <u>James Deemling</u> RESIDENCE <u>Rose Lake</u> COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>43</u> (Years) BIRTHPLACE <u>St. S. Dak</u> OCCUPATION <u>laborer</u>	FULL MAIDEN NAME <u>Helen Morse</u> RESIDENCE <u>same</u> COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>35</u> (Years) BIRTHPLACE <u>Minnesota</u> OCCUPATION <u>housewife</u>
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CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 192.....

(Signature) H. H. Braden
(Physician or midwife)

Address Rose Lake - Idaho
Filed Jan 19 1927 R. D. Deemling
Registrar. Registrar.

1940.

10-11-64

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 12 1927
PLACE OF DEATH

STATE OF IN
DEPARTMENT OF PUBLIC
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 56301

County of Koolauai
City of Rose Lake

Registration District No. 30
Primary Registration District No. 1051
(No. _____)

Local Registrar's No. 1096

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Dunning

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Dec 15 26

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Rose Lake
(State or country) Idaho

10 NAME OF FATHER James Dunning

11 BIRTHPLACE OF FATHER (city or town) S. Oak
(State or country) _____

12 MAIDEN NAME OF MOTHER Walter Morse

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country) _____

14 Informant H. F. Schrader
(Address) Rose Lake

15 Filed Jan 10 1927 H. F. Schrader
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 15 26
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1926, to Dec 15, 1926.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Still born

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) H. F. Schrader M. D.
Dec 15, 1926 (Address) Rose Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Rose Lake, Id. Date of Burial 12-26 1926

20. Undertaker none Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

391-105.035-364
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

County of Myer
City of Leicester
No. R.D. #2 St. Registration District No. 95 State File No. 148950
Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____
FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child M Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth 12-5 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FULL NAME FATHER Charles Crable

FULL MAIDEN NAME MOTHER Olivia Boulton

RESIDENCE Leicester Ida. R.D. 2

RESIDENCE Leicester Ida. R.D. 2

COLOR W AGE AT LAST BIRTHDAY 31 (Years)

COLOR W AGE AT LAST BIRTHDAY 28 (Years)

BIRTHPLACE Okla.

BIRTHPLACE Kola.

OCCUPATION adding machine salesman

OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at _____ M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) _____

(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed _____

Registrar.

Registrar.

8

;

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WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

695-106-
PLACE OF BIRTH

RECEIVED FEB 19 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

149282

003-432
County of Bannock
City of Pocatello

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 28 State File No. _____
Hospital St. Anthony Primary Registration District No. 2141 Local Registrar's No. 805

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? yes Date of birth 8 / 6 / 1926
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Silver Nitrate Sol 1%

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME James W. Winkler
RESIDENCE 355 North Lincoln
COLOR white AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Texas
OCCUPATION Salesman

MOTHER
FULL MAIDEN NAME Margaret Ann McBurnan
RESIDENCE 355 North Lincoln
COLOR rw AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Norwich Kansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } { Stillborn } at 4 45 P. M. on the date above stated.

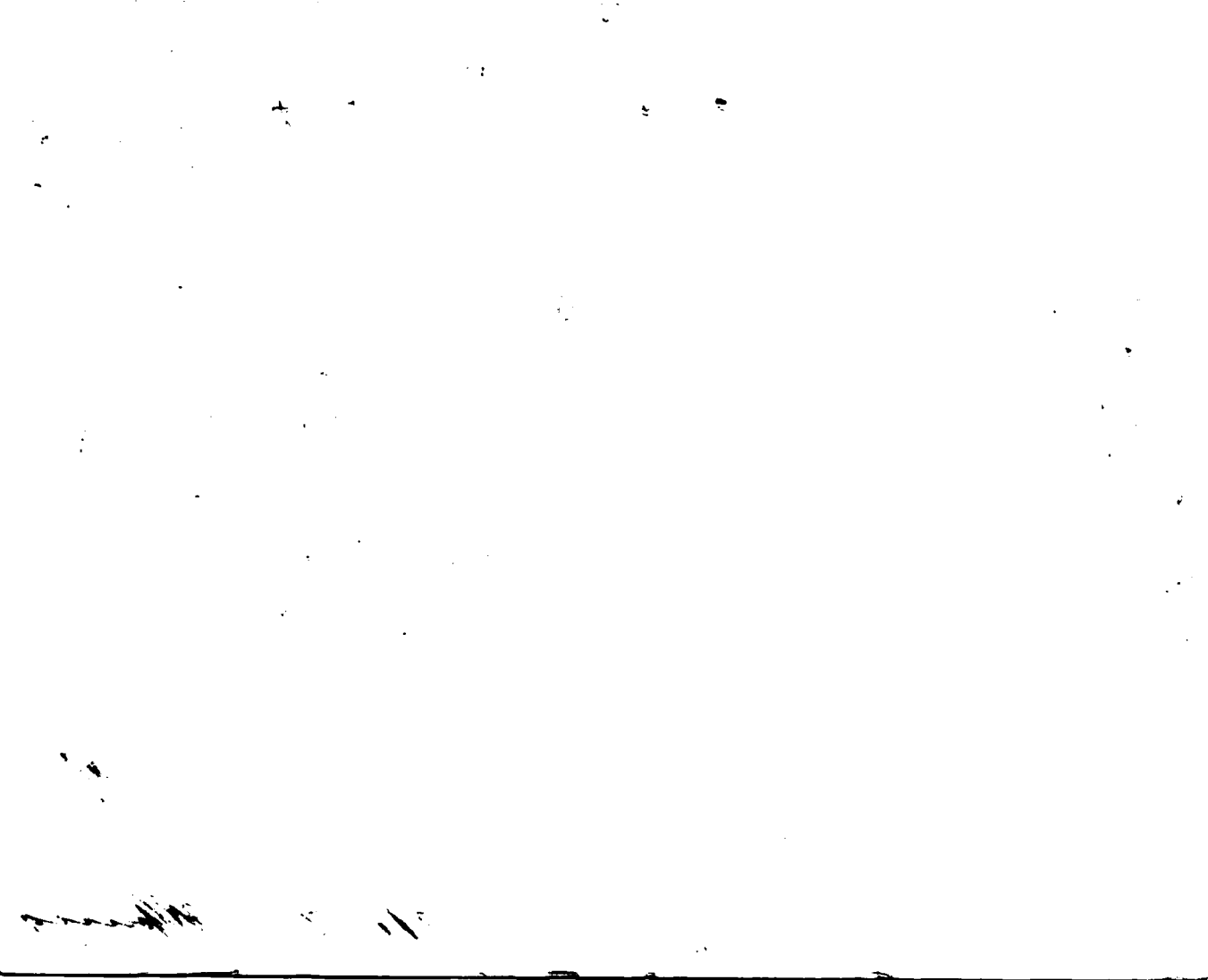
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Wm. Brothers

Address Pres. L. L. L.

Filed 21 1927 Alf. Brown Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Banner*
City of *Forestburg*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant (Winkler)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1926

Local Registrar

SEP 10

BUREAU OF VITAL STATISTICS

Primary Registration District No.

St. Anthony Hospital

2141

28

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

State File No. 54394

Registrar's No. 4466

16. DATE OF DEATH

17. I HEREBY CERTIFY That I attended deceased from

that I last saw h. alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory (Secondary) Parental syphilis

(Signed) W. W. Brothers M. D.

8-7-1926 (Address) Portland, Ore.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

20. UNDERTAKER

Mountain View

Address

City

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, "Foreman, "Manager, "Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers, who receive a definite salary,** may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**") **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia,**" unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, "Anaemia**" (merely symptomatic), "**Atrophy, "Collapse, "Coma, "Convulsions, "Debility, "Congenital, "Senile, etc., "Dropsy, "Exhaustion, "Heart Failure, "Hemorrhage, "Inanition, "Marasmus, "Old age, "Shock, "Uraemia, "Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

139-122010-214
PLACE OF BIRTH

RECEIVED MAR 7 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonneville

City of Shaks Falls

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 73 State File No. 149450

Hospital C.D.S. Primary Registration District No. 2145 Local Registrar's No. 1-4

FULL NAME OF CHILD Baby Aldous

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	} and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>7-22-</u> 192 <u>6</u> (Month) (Day) (Year)
--------------------------	---	--	-----------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FULL NAME <u>Jos. Archie Aldous</u>	FATHER
RESIDENCE <u>Shelley</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Drug girl</u>	

FULL MAIDEN NAME <u>Hazel Bauer</u>	MOTHER
RESIDENCE <u>Shelley</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Housekeeper</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 525 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Edwin Carter

(Physician or midwife)

Address Shelley Idaho

Filed 2/19 1927

Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 8 1926

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonneville Registration District No. 23
City of Idaho Falls Primary Registration District No. 2140
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State File No. 54761
Local Registrar's No. 142

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

9 - 22 - 1926
(Month) (Day) (Year)

7. AGE

stillborn IF LESS than 1
day how many
hrs. or
Yrs. Mos. ds. min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

stillborn

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
Father

Jos. Archie Aldous

11. BIRTHPLACE
OF FATHER

(State or Country)

Utah

12. MAIDEN NAME
OF MOTHER

Hazel Bauer

13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph Archie Aldous
Shelby Idaho

15.

Filed

Oct 23

1926

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 - 22 - 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
9-22-1926 to 9-22-1926

that I last saw him alive on 1926

and that death occurred on the date stated above, at Idaho Falls, ID.

The CAUSE OF DEATH* was as follows:

decompression of
thorax

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin Carter M. D.

9-23-1926 (Address) Shelby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls Crematorium

9-23-1926

20. UNDERTAKER

ADDRESS

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED APR 6 1927

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Jefferson

City of Roberts Star route

CERTIFICATE OF BIRTH

150443

No. 912 228 826 795 St.

Registration District No. 98

State File No.

Hospital

Primary Registration District No. 2176

Local Registrar's No. 80

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child F

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth
(To be answered only in event of plural births)

Legiti-
mate? Yes

Date of
birth. 17 28
(Month) (Day) (Year)

1927

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR W

AGE AT LAST
BIRTHDAY 25
(Years)

COLOR W

AGE AT LAST
BIRTHDAY 17
(Years)

BIRTHPLACE Wash

BIRTHPLACE Arizona

OCCUPATION Rancher

OCCUPATION House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 9 AM M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Earl Lynes

(Physician or midwife)

Address Roberts

Filed Apr. 10 1927

Registrar.

Registrar.

24405

SECRET

NO. 10

100-443887-100

1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808

... ..

10/10/1944

[Illegible text]

... and it was a relief to me to meet you.

100-443887-100

100

100-443887-100

30A-147071

NOTATION

1-10-68

[illegible]

SECRET

[illegible]

1992

[illegible]

RECEIVED 1974

...the ...
...the ...
...the ...
...the ...

100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098

1. $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$ (the probability of getting heads on both coins)

...and the fact that the *Journal* is a journal of the American Psychological Association, the largest and most influential of the professional organizations in the field of psychology.

the 1990s, the number of people in the United States who are 65 years of age or older is projected to increase from 20 million to 35 million, and the number of people 75 years of age or older is projected to increase from 10 million to 15 million (U.S. Census Bureau, 1996).

1977-1978

... ..

90-6000-1078

NOTA: 100

CONFIDENTIAL

10. The following information is for your information:

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-14-2014 BY 60322 UCBAW

10-10-68

10. The following information is being furnished to you for your information:

100-443887-100

100

MARGIN RESERVED FOR BINDING

156443

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 56932

PLACE OF DEATH

County of Jefferson
City of Roberts

RECEIVED APR 11 1927
CERTIFICATE OF DEATH
Registration District No. 98
Primary Registration District No. 2176

Local Registrar's No. 5

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME No name Still born
(a) Residence. No. Roberts, Idaho St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. Single, Married, Widowed, or Divorced (write the word) Baby
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) Dec 28-1926
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED Stillborn
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) (State or country) Roberts, Ida.
10. NAME OF FATHER Weldon R. Rash
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Iris Loretta Green
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arizona

14. Informant Weldon R. Rash
(Address) _____

15. Filed Apr 10 27 Ray H. Fisher Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 28 1926
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows: Stillborn

Not syphilitic. Probably due to exhaustion following long labor. (duration) _____ yrs. mos. ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. mos. ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? _____

(Signed) Paul Jones M. D.
Dec 29, 1926 Address Roberts, Idaho
Ray H. Fisher

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Roberts Date of Burial Dec 29 1926

20. Undertaker Friends Address Roberts Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

296-129 038-389

PLACE OF BIRTH

RECEIVED

MAR 21 1927

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C--25m-7-21-19

County of Payette

CERTIFICATE OF BIRTH

City of PayetteRegistration District No. 4File No. 150646

No. _____ St. _____

Hospital BlanchardPrimary Registration District No. 1008Registered No. 2

FULL NAME OF CHILD

unnamed (stillborn)Sex of
ChildMTwin
Triplet
or other?✓

and

Number
in order
of birth✓Legiti
mate?yesDate of
Birth12-29-1926

(Month) (Day) (Year)

FULL
NAMEJohn Brosnan

FATHER

RESIDENCE

ONTARIO, OREGON

COLOR

W

AGE AT LAST

BIRTHDAY

29

(Years)

BIRTHPLACE

ONTARIO, OREGON

OCCUPATION

RancherFULL
MAIDEN
NAMELerna Chize

MOTHER

RESIDENCE

ONTARIO, OREGON

COLOR

W

AGE AT LAST

BIRTHDAY

36

(Years)

BIRTHPLACE

Prineville Ore

OCCUPATION

House wifeNumber of child of this mother, including present birth 1Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn
on the date above stated.

(Born alive or stillborn)

at 11 P. M.

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

R.O. PayneP. & S.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

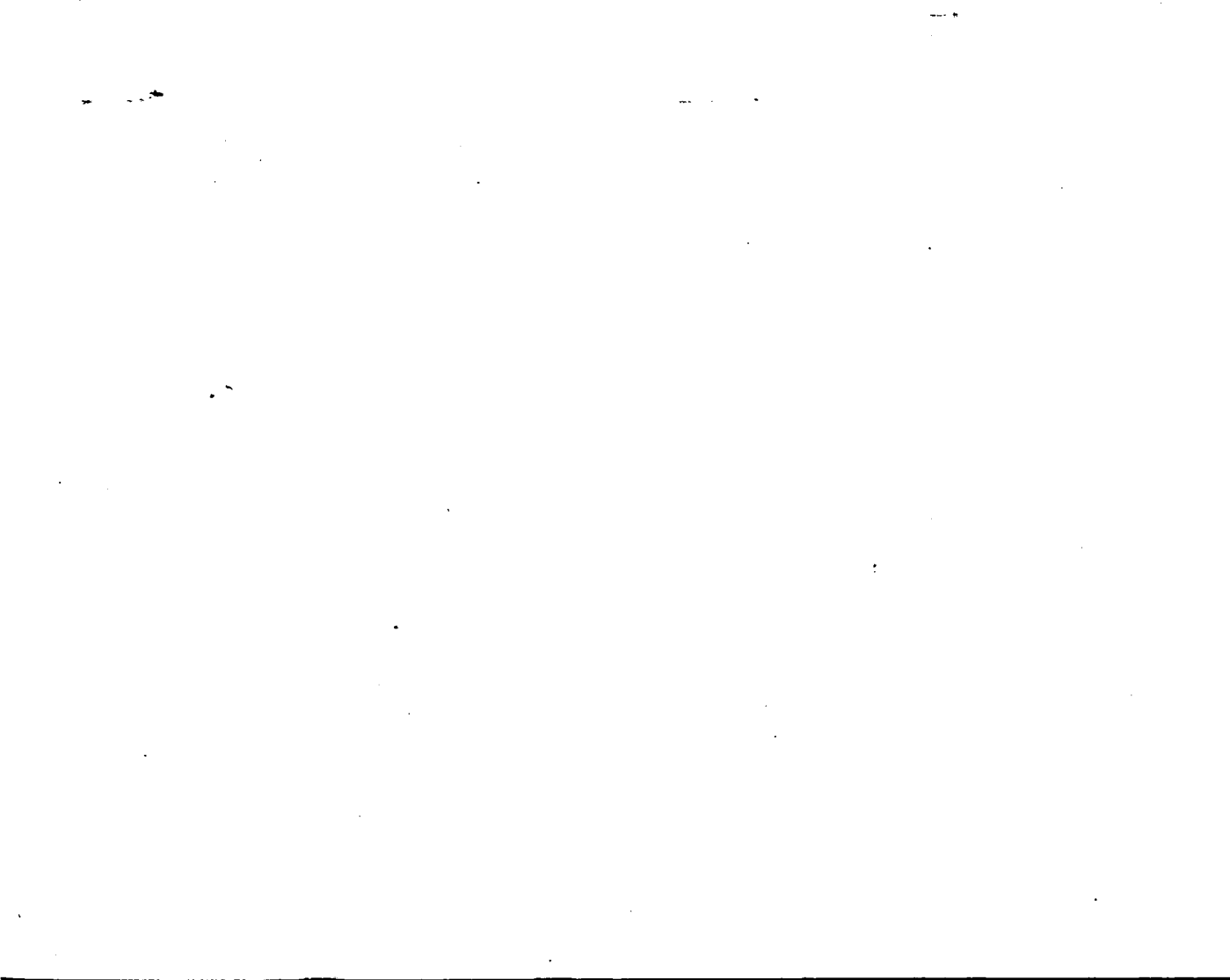
ONTARIO, OREGON

Filed

Jan 10 1927

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

57016

State File No.

Local Registrar's No.

RECEIVED MAY 10 1927

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Payette

City of Payette

Registration District No. 4

Primary Registration District No. 1008

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

St.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

189-5

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

✓

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Infant

9 BIRTHPLACE (city or town)
(State or country)

Payette

10 NAME OF FATHER

John Brozman

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Vienna Chase

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

B Columbia

PARENTS

14 Informant

(Address)

Mrs. J. Brozman
Payette, Idaho

15 Filed

Jan 10 27
J. C. Woodward
Registrar

16 DATE OF DEATH

12
(Month)

29
(Day)

1926
(Year)

17

✓ I HEREBY CERTIFY, That I attended deceased from
19... to 19...

that I last saw him alive on 19...
and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH was as follows:

Still born

(duration) yrs. mos. ds.
CONTRIBUTORY Eclampsia mother.
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ONTARIO, OREGON
if not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed)

R. O. Taylor, M. D.

1-4-27 (Address) ONTARIO, OREGON

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Ontario Ore

12-3-1926

20. Undertaker

Address

Payette Co Payette Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc.; Carcinoma, Carcoma, etc., of _____ (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as: "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. All diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

469-104 040-239
PLACE OF BIRTHRECEIVED APR 6 1927
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSCounty of ShoshoneCity of Kellogg

No. _____ St. _____

Registration District No. 123State File No. 150669Hospital WadnerPrimary Registration District No. 2201Local Registrar's No. 26

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>12/4/1926</u> (Month) (Day) (Year)
--------------------------	--	-----	---	-----------------------------	---

What bactericidal solution was used in eyes? NoneNumber of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER FULL NAME <u>Henry Drendorff</u>	MOTHER FULL MAIDEN NAME <u>Wilhelmina Bliesner</u>
RESIDENCE <u>Kellogg, Idaho</u>	RESIDENCE <u>Kellogg, Idaho</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>31</u> (Years)	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Miner</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 29 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) A. S. MacDonnell

(Physician or midwife)

Address Kellogg, IdahoFiled Nov. 31, 1927

Registrar.

Registrar.

RECEIVED JAN 5 1927

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
City of Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2201
(No. _____ St.)

State File No. 5579
Local Registrar's No. 117
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Doremborg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word)

6. DATE OF BIRTH Dec 4, 1926
(Month) (Day) (Year)

7. AGE _____
IF LESS than 1 day how many _____ hrs. or _____ min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Henry Doremborg

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Miss Blaesner

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Doremborg
(Address) Idaho

15. Filed Dec 6 - 1926 Mrs. Helen M. Zwick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 4, 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/4/1926 to 12/4/1926 that I last saw h. still living alive on 12/4/1926 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Toxemia of Pregnancy.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. J. Macdougall M. D. (Address) Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Idaho DATE OF BURIAL Dec 4, 1926

20. UNDERTAKER M. C. Thornhill ADDRESS Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH MAY 6 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 151039

County of Boundary

City of Bonner Ferry

No. 793206011-154 St.

Hospital Bonner Ferry

FULL NAME OF CHILD Baby Gillard

Registration District No. 79

State File No. 151039

Primary Registration District No. 956 Local Registrar's No.

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Jan 6 1926</u>
(To be answered only in event of plural births)			(Month) (Day) (Year)	

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Frank Joseph Gillard
RESIDENCE Bonner Ferry Idaho
COLOR White AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Michigan
OCCUPATION Barigman

MOTHER
FULL MAIDEN NAME Georgia Andre
RESIDENCE Bonner Ferry Idaho
COLOR White AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Michigan
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 8 77 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. , 1926

(Signature) R. M. Bowell
Physician
(Physician or midwife)

Address Bonner Ferry Idaho

Filed Dec. 8 1926 S. E. Fry
Registrar. Registrar.

RECEIVED MAY 6 1927

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

57162

State File No.

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonner
City of Bonner FerryRegistration District No. 29Primary Registration District No. 3156(No. Bonner Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Baby Gellard

(a) Residence. No. _____ St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Infant

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Bonner Ferry Idaho

10 NAME OF FATHER

Frank Joseph Gellard11 BIRTHPLACE OF FATHER (city or town)
(State or country)Michigan

12 MAIDEN NAME OF MOTHER

Georgia Andre13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Michigan

14 Informant

(Address)

Mrs. Georgia Gellard
Bonner Ferry Idaho

15 Filed

Dec 6 1926

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 6
(Month)1926
(Day)1926
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

StillbornCONTRIBUTORY (Secondary) (duration) _____ yrs. _____ mos. _____ ds.
difficult labor - fibroid uterus

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

R. M. Bonnell

M. D.

Dec 6, 1926 (Address) Bonner Ferry Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Bonner Ferry, Ida.Dec. 6 1926

20. Undertaker

Address

H. R. CrouchBonner Ferry, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

912-100-003-689

PLACE OF BIRTH JUL 5 1927

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

County of Bonneville
City of Grace, ID

Registration District No. 84 File No. 152614

No. _____ St. _____

Primary Registration District No. 2160 Registered No. 361

Hospital _____

FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of Birth _____ (Month) (Day) (Year) <u>1926</u>
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FATHER
FULL NAME Martin Tash
RESIDENCE Grace ID
COLOR White AGE AT LAST BIRTHDAY 44 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Sella White
RESIDENCE Grace ID
COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 6 a. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) John Hubbard
Physician or midwife
(Physician or midwife)

Given names added from a supplemental report.

Address Grace Idaho
Filed 6-25-1927 Mr. J. J. Fish

Registrar

Registrar

COZDINE BOY, ESTABLISHED MIDWINTER
 CLOTHING FASHIONERS A 21 CENT AT DISCOUNTS BETTER QUALITY APPAREL
 SHOP TOP QUALITY 100% COTTON T-SHIRTS & JACKETS - all sizes 900 pairs store to save 50% - 50%
 fabric brand to reduce 50% to 70% off retail still huge

REPT TYPE OF CHILD

(To be
 or other
 T (p
 T-1

RESIDENCE

AGE 30-40

10-10-68

03041400

Number of child at this mother, including

I hereby certify that I attended the

When there was no attending physician, the patient was attended by the nearest neighbor, who was usually a woman. The patient was usually attended by the nearest neighbor, who was usually a woman. The patient was usually attended by the nearest neighbor, who was usually a woman.

...moleguse a mag? bobba emmed nrvia

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 24

Primary Registration District No. 2

Lentini

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Page 10 (Continued)